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PAY DETERMINATION FOR NURSES:
PAY REVIEW, GRADING AND TRAINING IN THE 1980s

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SUMMARY

This thesis develops a policy-oriented account and evaluation of pay determination and associated employment changes for U.K. nursing staff in the 1980s, within an analytical framework for understanding nursing pay processes and outcomes over longer time horizons and with greater generalisability. In particular, an analysis is conducted of the Pay Review Body for Nurses and Midwives and of the interlinkages between pay determination, grading and training at different levels of aggregation. The study is multidisciplinary, employing a wide range of primary documentation, and findings from national-level interviews and local case studies at eight district health authorities in the West Midlands region.

The thesis divides into three parts. The first locates nursing pay determination in historical context. Structural characteristics in the health division of labour and in the wider political economy lend a degree of apparent continuity to nursing pay levels. However, this appearance masks important change which must also be understood. The second evaluates the origins of nursing pay review, its processes and outcomes. The conflicting bargaining positions and power relations between the 'Sides' in pay review are noted, together with the continued importance of negotiation and of 'non-pay' issues. The role of the Pay Review Body is considered alongside nursing pay outcomes. Although the Review Body could be seen as contributing to conservative outcomes for nurses' pay, there are complex feedbacks within the system which must also be understood. The third section considers 'non-pay' issues and the interplay of national and local forces in an evaluation of local managerial perspectives on nurse resourcing and employment changes in the 1980s. It is argued that a 'crisis' occurred in the late 1980s, rooted in history and political economic circumstance, and that the process of pay decentralisation should be understood in this light. This process, however, is a risky and uncertain one.

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LIST OF ABBREVIATIONS

ACAS	Advisory, Conciliation and Arbitration Service
AEI	Average Earnings Index
AFPRB	Review Body on Armed Forces Pay
AWA	Asylum Workers' Association
BMA	British Medical Association
CHC	Community Health Council
CIP	Cost improvement programme
COHSE	Confederation of Health Service Employees
CRE	Commission for Racial Equality
CSO	Central Statistical Office
DDRB	Review Body on Doctors' and Dentists' Remuneration
DOCAS	Deduction of contributions at source
DoH	Department of Health
DHA	District Health Authority
DMU	Directly managed unit
EN	Enrolled Nurse
ENB	The English National Board for Nursing, Midwifery and Health Visiting
EOC	Equal Opportunities Commission
EPA	Employment Protection Act
FHSA	Family Health Service Authority
FPC	Family Practitioner Committee
FPS	Family Practitioner Services
GNC	General Nursing Council
GP	General (Medical) Practitioner
HA	Health Authority
HCA	Health Care Assistant
HCHS	Hospital and Community Health Services
HD	Health Departments
HMC	Hospital Management Committee
HMSO	Her Majesty's Stationery Office
HPSSS	Health and Personal Social Services Statistics
HSC	Health Services Committee
HSWU	Hospital and Welfare Services Union
HT	Hospital Trust
HVA	Health Visitors' Association
IDS	Incomes Data Service
IGS	Income generation scheme
ILO	International Labour Organisation
IMS	Institute of Manpower Studies
JBCNS	Joint Board of Clinical Nursing Studies
MHIWU	Mental Hospitals and Institutional Workers Union
MSEv	Management Side Evidence to the Review Body
N&M	Nurses and Midwives
NA	Nursing Auxiliary
NAO	National Audit Office
NAHA	National Association of Health Authorities
NAHAT	National Association of Health Authorities and Trusts
NALGO	National and Local Government Officers Union

NAWU	National Asylum Workers Union
NBPI	National Board of Prices and Incomes
NEDO	National Economic Development Office
NCVQ	National Council for Vocational Qualifications
NES	New Earnings Survey
NHS	National Health Service
NHS ME	NHS Management Executive
NMC	Nurses and Midwifery Staffs Negotiating Council
NS	Nursing Standard
NT	Nursing Times
NUCO	National Union of County Officers
NUPE	National Union of Public Employees
NVQ	National Vocational Qualification
OME	Office of Manpower Economics
P&T	Professional and Technical
PAM	Professions Allied to Medicine
PES	Public Expenditure Survey
PLWTU	Poor Law Workers Trade Union
PQ	Parliamentary Question
PRB	Pay Review Body for Nursing Staff, Midwives, Health Visitors and Professions Allied to Medicine
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RDSHA	Regional, District and Special Health Authorities
RGN	Registered General Nurse
RHA	Regional Health Authority
RHSG	Radical Statistics Health Group
RPI	Retail Price Index
SEN	State Enrolled Nurse
SHVA	Scottish Health Visitors Association
SRN	State Registered Nurse
SSC	Social Services Committee
SSEv	Staff Side Evidence to the Review Body
TAPPI	Target average percentage pay increase
TSRB	Review Body on Top Salaries
TUC	Trades Union Congress
TULRA	Trade Union and Labour Relations Act
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting
WTE	Whole-time Equivalent

For my father

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CHAPTER ONE

INTRODUCTION

THE SIGNIFICANCE OF NURSING PAY DETERMINATION

The magnitude of the nursing paybill makes the determination of nurses' pay one of the most important areas of NHS and public sector pay policy. The paybill for nurses and midwives, at over five billion pounds for England alone, is the largest single element of NHS expenditure. The paybill accounts for approximately 36% of the Regional, District and Special Health Authorities (RDSHA) revenue expenditure and 47% of total RDSHA salaries and wages. The RDSHA sector itself accounts for over 70% of all NHS expenditure. The nursing paybill generally increased as a proportion of expenditure in the 1980s, with a slight dip in the early 1990s. The RDSHA sector of the NHS is highly labour-intensive; the ratio of the current to capital accounts is 9:1, with wages accounting for nearly 80% of the current account (all figures for England, 1991, calculated from HPSSS, 1992:15-27).

The size and significance of the nursing workforce means that wage policy impacts heavily upon health service resourcing and provision, and has an important effect on the labour market more generally. The NHS nursing workforce in Great Britain is composed of over half a million people, or around 485,000 whole time equivalents (WTEs) (PRB, 1992:23) and accounts for around half of RDSHA employment. Nurses form the largest single occupational group in the NHS, which is itself one of the largest single sources of employment in Western Europe with over one million workers. Nurses also form the largest single occupational group in the overall public sector and account for some 2% of the national labour force.

At the same time, the characteristics of the nursing workforce and employment make wage policy an intrinsically interesting area. The vast majority of nurses are women - 90% in 1992 - and just under 40%

work part-time. There has been little significant change in either aggregate characteristic over the past decade (Thornley & Winchester, 1991:Section 1; HPSSS + NHS Workforce, various years). Contrary to popular belief, most nurses are aged over thirty (NHS Workforce,1992). In the labour market more generally, nursing 'has long been regarded as the most extreme example of the influence of gender on occupational choice', while within the NHS it exhibits patterns of horizontal and vertical segregation with associated low pay and gender inequalities (Thornley & Winchester,1991,ibid:4; see also; NUPE,1990; EOC,1991). Studies have also recorded the significant presence of black and ethnic minority nurses and shown evidence of racial inequality and discrimination (Salvage,1985:38; Pearson,1987; COHSE,1990:2; Kings Fund,1990; CRE in IRS,1992:8). Nurses are also highly differentiated by 'skill' and type of service provision. Over half the nursing workforce is categorised as 'qualified' (enrolled or registered), and nurses are predominantly employed in general nursing, followed by mental illness and handicap and care of the elderly, with varying proportions of 'skillmix' in each type of service. Sectoral change has also occurred, with the number of nurses employed in the independent healthcare sector increasing substantially in the 1980s to just under 60,000 in 1988 (Buchan, NS,1990; NAO,1989).

The 'vast majority' of nurses are members of some form of representative organisation (Salvage,1985:108), with the three trade unions, the RCN, COHSE and NUPE, accounting for the vast bulk of membership and six other unions and professional associations accounting for the rest. These organisations have very different histories and nursing membership (Thornley & Winchester,1991:Section 2; Seifert,1992:Chapter 2). Membership trends between the RCN and the TUC-affiliated unions, COHSE and NUPE, have changed sharply in the 1980s. The nursing workforce is internally differentiated by all the above characteristics. Women, and older women in particular, part-timers, and ethnic minorities are disproportionately represented in the lower parts of the nursing hierarchy. These characteristics are replicated unevenly in different parts of the service and in different representative organisations and qualifications are similarly

distributed (Doyal,1979; Salvage,1985). There is evidence that class characteristics are an important factor (Stacey,1988:189-190).

A wide-ranging series of changes has taken place in nurses' wage determination, grading and training since 1979. Nurses' wage determination, since the establishment of the NHS in 1948, consisted of a highly-institutionalised and centralised process of national, multi-employer collective bargaining, organised through the Whitley Council system of a General Council and Functional Councils. In 1982, however, a Pay Review Body (PRB) was set up for nurses, midwives and health visitors, with national agreements covering a small number of terms and conditions of employment common to all NHS staff still being concluded in the forum of the General Whitley Council, and terms and conditions of service for nurses other than pay being negotiated in a Nurses and Midwifery Staffs Negotiating Council (NMC). Senior nurses were later separated out from common consideration by the PRB.

The NHS reforms contained in the 1990 NHS Act included the potential for NHS Hospital Trusts (HTs) to determine pay locally, and various forms of decentralisation of pay determination have also occurred under the auspices of the PRB. A major job evaluation exercise was also carried out; the clinical grading review of the mid to late 1980s. At the same time, changes in the type and organisation of training have occurred, including the development of Project 2000 and National Vocational Qualifications (NVQs). These changes have occurred in the context of changes in the application of strict cash limits and 'efficiency' drives, and at a time of organisational and administrative restructuring, much of which has been seen in the public sector more generally.

RESEARCH FOCUS AND ANALYTICAL FRAMEWORK

The research is structured around three main aims. Firstly, a primary objective is to provide an integrated and up-to-date account of nurses' wage determination, with particular emphasis on the 1980s. It was felt that this would be useful to policy-makers, unions, managers,

researchers, academics and, above all, nurses themselves as no major academic work has appeared on this topic. A preliminary research report, written jointly with David Winchester, for the International Labour Organisation in Geneva (1991/1993), reveals striking gaps in the extant literature.

Secondly, the research aims to develop an analytical framework for nurses' wage determination. The rapid pace of change in the 1980s suggests the need to evaluate the role, process, outcomes, and strategies of the actors in wage determination, defined here as government, arbitration and review bodies, management and employee representative organisations. An important objective is to present an analysis of bargaining strategy, and to examine the validity of arguments used in the bargaining process. This, in turn, provides a perspective from which to evaluate the 'market forces' argument which has been so influential in the 1980s. A further aim is to explore the different levels (national, intermediate and local) at which wages are determined as well as the interlinkages between pay and 'non-pay' factors, such as grading and training and the personal characteristics of nurses and the significance of recent changes in 'non-pay' areas of nursing employment.

The third major objective is to explore the wider theoretical implications and policy relevance of this analytical approach. The 1980s have seen an increase in the literature on public sector industrial relations, many of which have shared an interest in the apparent moves to wage and industrial relations decentralisation, often in the context of analyses of government's shift from its perceived role as model employer (see Thomson,1983; Capelli,1983; Ferner,1985, Fredman & Morris,1989; Mailly et al,1989; Kessler,1990; Corby,1991; Davies,1991; Colling,1991; Ferner & Colling,1991; Pendleton,1991). It is felt that this work provides fertile ground for comparison and theoretical development, in which some of the more diverse analytical ideas contained in the framework of the thesis can be incorporated.

Because of the relative lack of a unified theoretical foundation, part of the challenge of the thesis is to explore an appropriate framework within which to analyse nurses' pay determination and to integrate a diverse policy, industrial relations and economics literature. This has proceeded on three main levels. Firstly, an exploratory historical and empirical evaluation of the nature of healthcare, nursing and nurses' pay determination is undertaken to contextualise the more detailed evaluation of recent trends. This approach gives insights into historical continuities in nursing pay determination and locates pay determination as the nexus of a much wider set of political and social interactions. The historical analysis exposes and clarifies the conflict-driven nature of nurses' pay determination and the importance of power disparities between and within the 'sides' to negotiation. This disequilibrium is further complicated by the existence of mediating structures and processes. The importance of different levels of aggregation and of considering 'non-pay' issues, such as grading and training, is also intimated. The emphasis on historical and structural continuities suggests some interesting analytical questions on how and why change occurs. However, in this complex process, the main forces working to determine nurses' pay are still obscured by the level of aggregation.

The second analytical focus of the thesis works by taking a shorter historical period and examining nursing pay determination at increasingly lower levels of aggregation to further clarify the main forces in pay determination. This is undertaken by using the pay review process and pay outcomes in the 1980s to evaluate the strategies of the parties to the process and the role of mediating structures. This form of analysis enables clarification of the continuity versus change theme and suggests the need for even lower levels of aggregation. In particular, the need to evaluate the role of local management and of underlying employment issues becomes clear.

The third focus of the thesis uses a combination of case studies at local level, and aggregate and fieldwork data on employment, to re-evaluate wider questions on the demand and supply of nurses and the

role of wage levels and wage determination. This returns the analysis full-circle to the issues raised by the historical and structural continuities and enables conclusions to be drawn on the role of the parties, mediating structures and processes, and current proposals for change in the level of nursing pay determination. It is concluded that the disproportionate power of government in the process lends some credence to the view that market forces work very weakly in what is largely a demand-driven system. However, the complex nature of the process has a number of powerful feedbacks which make pay policy in this area considerably more constrained than is commonly assumed.

The above analysis builds primarily and eclectically upon industrial relations and institutionalist policy-oriented literature, much of which has been stimulated by the relative poverty of neoclassical wage theory. While 'the process of wage determination is central to economic analysis' (Brown and Nolan,1988:339), it remains one of the most unsatisfactory areas in orthodox economic theorising and empirical study. Classical economic theory admitted the importance of social and political factors (see also Wood,1978), but neoclassical theory is based on the idea that the wages of labour can be explained in similar terms to the prices of commodities through the interaction of numerous individual transactors and the interplay of the market forces of supply and demand.

This form of analysis, based on a series of highly restrictive assumptions, leads to the conclusion at an economy-wide level that 'the rewards accruing to individuals can be wholly explained in terms of their respective marginal contributions to output and of the sacrifices entailed in the process' (Brown & Nolan,1988:343). Although there have been a number of recent developments in certain aspects of the theory, occurring largely under the rubric of institutional economics (see overview in Sawyer,1989), 'the observation of a far greater variety of wage outcomes than is predicted by that theory tends to be rationalised in terms of institutional rigidities' or poorly assimilated into the main body of labour economic theory (Brown and Nolan,1988:343). Thus, the

persistence of discriminatory wages, for example, remains particularly poorly explained (King,1990:122). Brown and Nolan conclude that wages are undeniably market sensitive phenomena but it is important to recognise that:

The wages of labour are not akin to the prices of commodities. It is an empirical question how far, in any particular society and circumstance, the market conditions of supply and demand dominate, or are dominated by, the influence of custom and political processes (1988:354).

For Barbara Wootton, neoclassical theory presented so many problems and was so unrealistic that the question of analytical approach is reversed: rather than starting from the point of an 'ideal type' model, she argued that the analysis could more reasonably flow from empirical observation back to inform theory:

the standing of a theory which explains wage structure in terms of a continual pressure towards equality of net advantages in all occupations, obstructed only by the practical difficulties of mobility, or by monopolistic manoeuvres, must in the end be judged by the measure in which these phenomena are perceptible in the real world (1955:27, see also Phelps Brown,1977).

The presence of trade unions also signals the need for empirical study. Neoclassical theory has largely treated unions as monopolistic 'institutional blockages' to the working of market forces. The possibility of bilateral monopoly is admitted only rarely and usually in the context of a theoretical 'extension' rather than as a fundamental characteristic of wage determination. The analytical point that a 'reconciliation of the "economic" and "non-economic" approaches' might be possible has also been raised by Reynolds (in Dunlop,1964:198) in that unions - and employers - may be strongly influenced by economic factors despite the apparent importance of custom and tradition in their behaviour. Though advanced mainly to counter the above 'doctrinaire view that trade unions, being "monopolies", must by definition have an adverse effect on the wage structure' (1964:221), it re-confirms the fact that the actual effects of trade unions remain a point for empirical investigation.

An emphasis on empirical observation might also be considered particularly pertinent for public sector pay determination. If pay determination is handled badly by much economic theory, public sector pay determination has received negligible attention. The few applied case studies of pay determination have been almost exclusively in the private, manufacturing sector and there has thus been limited theoretical development. Its consideration raises a particular conundrum for neoclassical theory which is based almost exclusively upon the normative 'ideal' of perfect competition and atomistic private enterprise. This concerns the conflicting objectives facing government pay policy; in particular the 'level' at which economic efficiency should be considered. At the macro level, public sector occupational wages could be determined as part of wider public sector pay and macroeconomic policy. At a lower level of aggregation, wages could be determined at the national level of occupational supply and demand. At yet a lower level, wages could be determined by the forces of supply and demand in a local labour market. Finally, wages at the micro level could be linked to worker productivity. There is no extant theory to suggest which is the 'appropriate' level of determination, either normatively or empirically, or how micro and macro objectives could be reconciled. The very rare references in public sector economics textbooks to public sector pay usually, in fact, implicitly assume that the macroeconomic objective is of primary importance (see, for example, Brown and Jackson, 1990) but with no particular justification.

Important considerations for the public sector have been raised by writers employing industrial relations and institutional frameworks and this tradition has strongly influenced the analytical framework for the thesis. These considerations concern the fact that government may have to balance quite different objectives and constraints apart from those which might be termed 'directly economic'. For example, electoral and wider political and social imperatives may be equally important and may include the need to minimise industrial conflict in sensitive service areas. The extent to which the forces of demand and

supply, at whatever level of aggregation, then work through thus again becomes an empirical question.

Wootton's outstanding study of the social foundation of wage policy has been very influential on the present framework. In particular, Wootton emphasised the important material effects that institutions, including mediating structures, and bargaining processes could have in wage determination and in conservative and rigid outcomes. Working at a less aggregate level, Clegg and Chester's 1957 seminal exploration of wage policy in the Health Service similarly pointed to the ambiguous nature of institutions and bargaining arguments and the importance of political factors. Allen (1960) explored the relationship between government and trade unions, including the public sector, more directly. The work of such authors, in particular, demonstrates the need to re-evaluate the significance of the 'model employer' concept for the NHS, and nurses in particular, and to take different employee representative organisations into account. More recently, this tradition of work in the public sector has expression in work which has signalled the importance of incomes policies, cash limits and levels of pay determination in any income-employment tradeoff (Winchester,1983) along with the re-consideration of normative questions about pay policy (Brown and Rowthorn,1990) and the need for national coherence in wage determination for public service workers (Brown and Walsh,1989). Seifert (1992) has also emphasised the importance of different representational forms and industrial relations traditions in understanding health service pay determination.

Finally, the main focus of the thesis on nursing pay determination raises fresh analytical challenges, which compound the above theoretical and empirical complexities and introduce the need to consider occupational characteristics such as gender, class, hierarchy, skills and forms of representation. In this respect, a wider literature from history, sociology and political economy has suggested some avenues of enquiry which are incorporated in the above analytical framework. The literature that focuses on health and the

nursing division of labour strongly suggests that forms of segmentation and associated forms of representation are vital to an understanding of nurses' pay determination (Doyal,1979; Salvage,1985; Stacey,1988; Carpenter,1988). Historical studies (Abel-Smith,1960; Dingwall et al,1988) have particularly raised the analytical dilemma of distinguishing between structural factors and government and trade union strategy, and raised the importance of non-pay factors such as grading and training.

These considerations link in turn to wider institutionalist and feminist theorising. Thus, writers such as Reich (1981), Gintis (1976, 1987) and Friedman (1977) have emphasised the way in which divisions within labour may serve to disunite labour and benefit capitalists, and raise questions about the strategic or structural nature of such divisions. Braverman (1974) has particularly questioned how concepts of skills arise and Gintis has suggested that 'wage differentials are in no way captured by technical capacities of workers...workers at different wage rates may be equally capable of executing the same tasks' (1987:79). Feminist writing has suggested the potential for considering patriarchy alongside productive systems (Walby,1986,1988) in understanding the gendered nature of some occupations and has, more recently, recognised the need to embrace the importance of internal institutional arrangements and pay structures in particular (Rubery,EOC,1992).

In summary, the analytical framework of the thesis draws from a diverse and multi-disciplinary literature and is constructed to contribute to some of the above debates through a study of the 'internal' institutional arrangements for nurses' wage determination, working from first principles and observable data and drawing eclectically from wider theory on 'external' structures from the preceding literature.

RESEARCH METHODS

A key feature of the research methodology has been to work from an aggregate level through to lower levels of aggregation. In part, this is dictated by the nature of the thesis, which focuses on national level wage and employment issues. However, this research design was also intended to ensure that the thesis remains generalisable and policy-relevant and to provide a point of comparison for lower-level and more impressionistic data. The fieldwork was designed to complement and deepen the analysis in certain areas, particularly by providing qualitative data on the perspectives of key actors and the constraints they felt they were under. A second major concern in the research design has been to evaluate processes against outcomes and vice versa, and this has meant that interviews and enquiries continued throughout the research period where particular controversies or data difficulties arose. The 'checks and balances' built into the research design proved useful on a number of occasions, particularly in exploring problems with aggregate data or with the occasional 'maverick' interview.

Three main categories of data and research methods were sought and employed: primary source documentation; national level interviews; and local level case studies.

Primary source documentation

Given the focus of the thesis, primary documentary sources were a particularly important source and are listed separately in the Bibliography in Sections II to IV. These sources included specialist health and nursing documentation and literature, and a number of HMSO and Hansard publications including: reports for all years from the Pay Review Bodies for Nurses and Midwives, Senior Nurses, and for selected years for other pay review groups; reports from prior pay reviews for nurses; White Papers and Acts; Select Committee Reports; Health and Personal Social Services Reports; NHS Workforce in England; CSO Blue Book; New Earnings Survey; Reviews of Whitley.

Published and unpublished documentation was also obtained from the Department of Health, UKCC, ENB, and other official bodies who have requested anonymity. Published health authority information was available in the form of NAHAT publications, and published and unpublished regional and district HA data, and internal documentation and studies circulated from the DoH to HAs, was made available during some of the case study interviews. An 'archive' of daily news clippings on nursing, health and the public sector was collected as a valuable source of up-to-date information. The Kings Fund library in London provided an excellent source of historical and current, practitioner and policy, articles and books as well as special studies undertaken by the Kings Fund itself.

Published and unpublished Management and Staff Side Evidence for most recent years was obtained, along with copies of specially commissioned reports and studies used in the pay review process. Full access to unpublished reports, studies, letters, consultation documents relating to the pay review process, changes in grading and training, and other focuses of the thesis was also enabled through the co-operation of officers from the main nursing trade unions and access to their own documentary archives and other sources. Data was obtained from the great majority of the professional associations and trade unions representing nurses, midwives and health visitors. TUC documents and letters were also obtained.

Interviews at national level

The main purpose of interviews at national level was to strengthen and deepen understanding of key issues and to obtain data and documentation which would otherwise have been unobtainable. Thirty semi-structured interviews were conducted with national and head office representatives of training boards, nursing specialists, trade unions and professional associations and, although the main emphasis was on collection of quantitative data, these proved fruitful for a preliminary investigation of qualitative issues. The trade union officers from the RCN, COHSE and NUPE responsible for preparing and

presenting pay review evidence were all interviewed, often on more than one occasion. Over forty additional contacts, both formal and less formal, to these national bodies and the DoH were made by telephone and correspondence, for both quantitative and qualitative data. Informal and social contacts with national and local trade unionists (General Secretaries, National Officers, legal, professional and research officers concerned with pay, equal opportunities, health and safety, and specialist areas of nursing) over a number of years proved invaluable for background data on the history, functions and strategies of the unions, and the personal commitments and perspectives of the trade unionists concerned.

'Case studies' at local level

The main purpose of the fieldwork at regional, district and local level with managers, trade unionists and staff was to deepen certain aspects of the research and complement other sources. The major objective was to clarify the relationship between national-level processes and outcomes and institutional objectives against the employment and work organisation needs of lower tiers in the structure. It was also felt necessary to get a more qualitative perspective from nursing professionals and managers at the 'sharp' end of provision of healthcare.

Preliminary interviews (ranging from one to three hours) were conducted at regional, district and local levels in the West Midlands region, which accounts for 10% of all NHS HA revenue expenditure. It was then decided to conduct a series of structured interviews, ranging in duration from one to three hours, at district level in the West Midlands region with nursing management. These districts were geographically randomized and gave a sample of rural, urban and inner-city areas and covered over one-third of the region. Follow-up interviews were conducted in one particularly interesting case and interviews were also conducted in nursing, general, financial and personnel management at district and unit level. Although the main emphasis of local fieldwork was to explore the perspectives of local

management, a number of trade union representatives from regional through to unit level were also interviewed on a less formal basis, along with individual nurses, midwives, health visitors, district nurses, nurses working for general practitioners and nurses working in the independent sector. The latter was a fruitful line of enquiry and remains an important area for further research and comparison. Around thirty interviews were conducted over the research period with the 'formal' district level interviews mainly conducted in 1990 and 1991.

STRUCTURE OF THE THESIS

Chapter 2 is a contextual chapter in which the main themes and analytical focus of the thesis are developed. It provides an account and evaluation of the historical development of healthcare and its division of labour, nurses' representative organisations and pay determination systems and outcomes. The role of grading and training are then explored.

A very diverse literature drawing on history, sociology, political economy and economics is brought together in the chapter. It is argued that the healthcare system and its division of labour both reflect and support the wider productive system and historical inequalities in class, gender and race. However, the 'system' has been prone to intermittent crisis due, in part, to the difficulty of making rational or consistent cost-benefit decisions and, in part, to the role of labour in influencing this calculation. The prior stratification of the nursing labour force is shown to have had a constraining impact on the 'effectiveness' of nursing representation. Maintaining the 'tension' between the power of trade unions and of professional associations, however, has been a delicate and difficult operation for capital. The ultimate supremacy of either 'professional' or 'trade union' aims represents a threat to cost-minimisation. It is argued that the creation of the NHS and the development of new pay determination systems represented some gains for labour, but also contributed to the maintenance of the status quo. Changes in the wider political economy had an important impact on

nursing trade unionism and such change also led change in the professional associations. An important argument in the chapter is that grade dilution, an alternative cost-minimisation policy to wage suppression, also laid the conditions for the growth of trade unionism. By the late 1970's, this threatened to challenge the status quo.

Chapters 3, 4 and 5 review one of the most critical of the changes affecting nursing employment in the 1980's, namely the establishment, process and outcomes of the Nurses and Midwives Pay Review Body which replaced the system of 'free' collective bargaining under Whitley.

Chapter 3 employs a range of published and unpublished primary documentation to examine the origins of the nurses' Pay Review Body and explore its pragmatic and theoretical rationale. A detailed analysis of prior forms of arbitration and review is conducted along with an account of the industrial unrest giving rise to the nurses' review body and the initial controversy surrounding its remit. The chapter then explores the precedents for a review body system for nurses in an evaluation of the other public sector review bodies and their operation to date. Finally, some preliminary conclusions are drawn on the theoretical rationale for review bodies.

It is argued that a close examination of prior arbitration and pay review bodies in nursing must locate these as mechanisms which are circumscribed by their times but have some commonalities in structure, process and outcomes. In particular, each of the three main exercises in 'pay-uplift' from the late 1960s increased differentials, and persisted in female-female pay comparisons. Moreover to whatever extent comparability was or was not stressed, the lack of a clear explanation as to how recommendations were arrived at must point to the need for caution in evaluating the significance of the comparability factor. The 'semantics' of the reviews very much reflected the degree of industrial militancy at the time. Most of the reports, however, were written using the jargon of economics, and 'efficiency' appeared, more or less explicitly, to be an important

aim. The reviews can be seen to be largely influenced by electoral 'cusps' followed by periods of deteriorating relativities in nurses' pay. Pay militancy continued to erupt, finally culminating in the establishment of the N&M PRB, which split NHS staff and 'officially' removed the 'free collective bargaining' from the determination of nurses' pay.

The government was concerned to define the scope of the PRB's deliberations and to skew the terms of reference to market forces terminology. In the review of the operation of review bodies established prior to the N&M PRB, it is argued that such an operation has been far from unproblematic; periods of fall-behind still occur, and, in the case of the DDRB, industrial action has not always been avoided. Comparability has persisted into the 1980s, again sometimes more and sometimes less explicitly, depending very much on the staff group concerned and the need to appease. Government shows a disproportionate power to influence outcomes in all cases and the important effect of avoiding 'head-on' confrontation is noted. In the preliminary consideration of a theoretical rationale it is argued that little justification can be found in liberal political economy and that more radical interpretations are required which, in turn, hinge on empirical investigation.

Following this line of enquiry, Chapter 4 analyses the structure and process of the PRB through a detailed evaluation and ordering of evidence and reports from published and unpublished primary documentation, supplemented by interview material. Some preliminary notes are made on the type of criteria employed in evidence and discussed in reports and recommendations. The chapter reviews and analyses the arguments put forward by both Sides and their reception by the PRB and apparent influence on outcomes where this is visible. It also explores the historical progression of the arguments and changes in their importance.

The main findings from the review of structure and process are as follows. Firstly, it is argued that, in line with findings in Chapter

Three, the structure of the PRB raises questions about its political economic location and apparent acceptance by Staff Side. Secondly, it is argued that the criteria employed are skewed from the outset and exhibit 'economistic' leanings, although Staff Side have frequently 'won' the argument on this basis and have exhibited great ingenuity and increasing sophistication in dealing with the arguments. Recruitment and retention has emerged as the most discussed criterion. On most criteria there has been significant dialogue between Management and Staff Side with the important exceptions of low pay and equal pay, despite their significance for nurses. The process still reveals deep conflict over pay and is influenced by underlying employment issues, decided or negotiated elsewhere, but vitally important to the pay determination process. Grading, training and employment levels are seen to be particularly important in this respect and the question is raised as to how far pay determination can be removed from apparently 'non-pay' issues and whether, in fact, conflict is driven to lower levels. In this latter respect, the role of the PRB in tempering or channelling conflict must be open to debate. It is further argued that the process has exhibited some very unexpected feedbacks in the publicity it generates and the ability of Staff Side to present a largely united front, particularly in later years over the low pay criterion, and to persist with a 'negotiating style'. Finally, the trend to decentralisation is noted, and the role of the PRB considered in this light.

An evaluation of pay outcomes is conducted in Chapter 5, using calculations and data from a wide variety of published and unpublished sources and the New Earnings Survey series. The analysis is split into paybill measure and comparisons and the exercise constitutes an attempt to develop a framework for rigorous analysis of pay outcomes. The chapter then develops an integrated conclusion on the impact of the Nurses and Midwives Pay Review Body: structure, process and outcomes considered together. The argument is contentious and against the conventional wisdom. Firstly, it is demonstrated that the widening of differentials and continuation of gender inequalities in pay for nurses mean that nurses have made few gains and some real

losses. Secondly, it is argued that the Pay Review Body must in the end be seen as a state institution which is instrumental in controlling pay, not least through the suppression of pay aspirations. The fact that government is seen to exercise disproportionate power in the review process does not invalidate this argument. Thirdly, it is argued that the crucial 'mechanism' in pay reviews more generally is the 'process' which legitimates an otherwise unacceptable structure and outcomes. However, this is by no means an unambiguous system. For example, it does not resolve lower-level effects of pay outcomes and it is argued that conflict is driven down to these lower levels. Moreover, the exercise holds some unexpected feedbacks.

Chapter 6 takes up this theme by exploring, mainly through fieldwork findings from the local 'case studies', the impact the PRB system has had on local nursing management and their perspective on the 'local' demand and supply for nurses. The findings in this chapter begin to highlight some of the crucial directions of power flows between different levels and the links between pay and 'non-pay' issues in nursing employment. In this way, more unpredictable feedbacks are analysed, particularly relating to service provision, nurse employment levels, work intensity and the role of 'professional' judgement. The main findings are that managers believed that while the levels of nurses' pay were not particularly at issue, wider resource constraints were. In particular, the strict application of national cash limits and underfunding of pay awards were seen to have imposed resource constraints at local level which had largely subordinated wider questions concerning 'pure' demand for nurses or supply-side problems, and could be viewed as a lack in effective demand.

The potential for non-labour savings was seen as very restricted, and grading, training, work organisation, employment levels and mix, and service provision therefore came into particular prominence. The fieldwork also revealed relatively negative attitudes to the possibility of local pay determination and performance related pay for nurses, particularly after the experience of clinical grading and the conflict raised during that process. For managers, a kind of crisis

point had been reached in the late 1980s and early 1990s which clinical grading had exacerbated. Most felt some kind of grade-mix dilution was inevitable, particularly given current training changes.

This perspective and the local findings are evaluated in Chapter 7. It is organised around the issue of 'reshaping the workforce' and explores the contradictions and conflict in nursing which re-address some of the main findings in Chapter 2. Here the 'non-pay' and underlying issues to wage determination are explored directly along with the main changes of the 1980s and early 1990s. This chapter employs a wide variety of primary and secondary documentation and fieldwork at national and local level. Firstly, the grade-mix changes of the 1980s are evaluated. It is argued that 'grade enrichment' in this period has to be understood as the outcome of a complex series of processes which are mainly premised on resource deficiencies. They include changes in employment levels and provision of healthcare, changes in composition of services, changes in training numbers, and sectoral shifts. It is suggested that managerial and professional judgement has also been an important influence on grade-mix outcomes and that this, in part, explains an attempt to circumvent nurse managers through changes in managerial structures.

The chapter explores recent changes in training and prospects for the 1990s in the drive to 'reprofile the workforce'. It is found that the training changes are contradictory and may put increased strain on a system already in crisis. The drive to 'reprofile' and decentralisation becomes, however, more understandable as a reaction to crisis. The concept of 'reprofiling' is explored by analysing the deep conflict over 'ideal models' of nursing and skills and valuation. It is argued, however, that this conflict will emerge in full force if reprofiling and decentralisation occur and may prove a very risky strategy, as may the strategy of attempting to marginalise professional judgement in management. Again, the difficulty of separating crisis-reaction from strategy on the part of government is emphasised but policy options are viewed here as very restricted.

The latter point is considered in more detail in the concluding Chapter 8. Here, the main findings of the thesis are summarised and their theoretical relevance considered in an evaluation of continuity and change in public sector and nursing pay determination. Finally, prospects for policy in the 1990s are considered, particularly with respect to the limits to decentralisation. It is argued that the thesis, by demonstrating the internal drive to decentralisation in nursing pay determination, paradoxically also demonstrates the degree to which policy is constrained.

CHAPTER TWO

NURSING AND NURSES' PAY IN HISTORICAL CONTEXT

This chapter sets a context for the evaluation of recent change in nurses' pay, grading, training and employment which is undertaken in the remainder of the thesis. Firstly, the historical development of nursing is located in the wider context of the development of healthcare and its division of labour. Secondly, the origins, nature and development of nursing representative organisations are explored. The historical development of nursing pay determination is then examined, and the evidence of nurses' pay levels prior to the 1980s is considered. Finally, an overview and evaluation of the importance of grading and training in pay levels and pay determination is provided.

THE DIVISION OF LABOUR IN HEALTHCARE

In this section, systems of healthcare, the development of the health division of labour and the movement of nursing from the domestic to the public sphere are located in the wider political economy. The modern form of nursing is seen to have deep historical roots.

Healthcare in the 16th and 17th centuries took place primarily in the domestic domain in rural areas where the vast majority of the population lived. Most of these activities were undertaken by women in the household which was organised around the patriarchal family - a domestic group in which the husband/father had power and authority. Domestic healthcare was supplemented by folk healers and a variety of mainly unqualified practitioners. All these categories of healers included women, except for the minute London College of Physicians, which had excluded them from the outset. There was some provision of care for the poor by the municipal authorities.

In the 18th century, the main provision of healthcare by women at home continued. However, concern with public health was increasing, with

the first quarantine regulations being instigated. Physicians, surgeons and apothecaries were growing more numerous and attempting to organise themselves professionally, and the forerunners of the modern teaching hospitals were appearing along with the development of clinical medicine. In this century, 'the scene was laid in the arenas of public health and curative medicine, in both home and hospital, for the development and triumph of biomedicine in the nineteenth century as a male-dominated and class-based profession' (Stacey,1988:59).

These early signs of a public healthcare system and a patriarchal medical division of labour were both hastened and extended by the rapid social and economic changes associated with the growth in dominance of the capitalist mode of production, distribution and exchange in the 19th century. The transition from feudalism to capitalism had already had 'savage effects on life (and death) in the countryside' (Doyal,1979:50). With the rationalisation of agriculture many workers also became either underemployed or unemployed, producing widespread poverty and a movement into urban areas and industrial employment. Towns and population growth expanded rapidly, housing and sanitation were atrocious and, from 1816, mortality rates increased, with the highest rates to be found in working class urban areas. Differences in morbidity were also sharpened between different social classes. Low wages, and a high demand for labour, drew women and children into waged-labour and, for working class women, this marked a tension between the domestic and public spheres of activity that persists today (see Doyal,1979:150). The combination of poor working conditions, housing and nutrition rendered working class families particularly susceptible to infectious diseases. These diseases became the major causes of death in the 19th century and social control was increasingly threatened by these conditions.

There were several different ways in which both the causes and effects of high mortality and morbidity under this system were addressed. Firstly, there were pressures for change at the level of the productive system itself, in terms of employment and work conditions and wages. Secondly, and with different emphasis, there were

pressures to reform or ameliorate living standards, especially housing and sanitation. Finally, there were pressures to reform healthcare, both in terms of access and provision.

The pressures came from a variety of individual, collective and institutional sources at local and national level. The dominant source of change has been much disputed, not least because of its fragmentary nature. However, significant improvements in mortality and morbidity began to feed through from about 1870 and it has been argued that these were due mainly to a combination of the effects of improvements in working class living standards and public health legislation (McKeown in Doyal,1979:56). According to Doyal 'curative medicine was still very limited both in its availability and its effectiveness, and...it is now widely accepted that it played little or no part in the reduction of the national mortality rate which began in the 1870s' (1979:141 - see also Walvin,1987:25). Healthcare or health care, therefore took a subordinate but linked role in the 19th century, though the desire of the working class to gain access to such care as was available and to improve its provision should not be underestimated. Its subsequent development may also have owed much to the potential expense and complexity of the alternative policy of cleaning up British cities (Walvin,1987:29), or of the more radical alteration of productive relations.

The contribution and growth of formal healthcare systems in the 19th century should therefore be set in context of the wider socio-economic system and changes occurring elsewhere under a broader definition of health. The systems which did emerge were strongly class-based in terms of both access and provision and reinforced existing patriarchal tendencies. It has also been argued that these systems played a powerful role in social control and moral regulation (see Doyal,1979:148, Dean and Bolton in Stacey,1988:65, Dingwall et al,1988:26). These forms are still visible in modern access and provision and have had a strong influence on the development of nursing and nursing representative organisations.

A characterisation of healthcare in the 19th century would run broadly as follows. The wealthy were generally treated at home by elite physicians and surgeons or engaged women or nurses; hospitals of any kind were an unattractive alternative at this time. The wealthier middle class also purchased private treatment at home or in the outpatients departments of voluntary hospitals. The lower middle class or better-off working class could purchase, through various funding schemes, treatment in voluntary hospitals or from doctors. The non-chronically ill working class and poor received some very limited philanthropic accommodation in voluntary hospitals but were mainly 'treated' in Poor Law workhouses or Poor Law hospitals and had limited access to doctors. Asylums and isolation hospitals treated the insane or infectious. Thus for the majority of the working class - and the majority of the population - healthcare still revolved mainly around the domestic domain:

for much of the century, the great bulk of Victorians relied, in times of illness, not upon doctors or hospitals, but upon the practice of traditional folk medicines and upon local, communal expertise (Walvin,1987:33).

Women in their homes or local paid women were more important than formalised care and doctors for much of the population until late into Victoria's reign for both nursing and healing (see also Peterson in Stacey,1988:86). Herbalism was also part of common practice and belief, and many people treated themselves. After the control of drugs in 1868 and the subsequent patenting of medicines by the new large drug companies, this trend increased. The old 'herbalist' substances were often incorporated into the 'new' medicines and even poor, working class people proved a lucrative new market for these companies (Walvin:ibid).

With respect to hospital provision and the formalisation of medicine and the medical hierarchy, the development of voluntary hospitals was spurred by doctors and by mid-century had become the main locus for medical education. There was thus a strong tendency to take 'interesting' and non-chronic cases. Philanthropic funding also ensured that admissions were restricted to the 'deserving' poor;

'patients were no more likely to be very poor than they were to be very sick' (Dingwall et al,1988:2). Partly because of these restrictions, other hospital provisions developed under the Poor Law. The differences in scale can be seen in figures for 1861; 11,000 patients in voluntary hospitals, 50,000 sick paupers (Abel-Smith,1964:49). The initial intention after the introduction of the new Poor Law of 1834 had been to treat the sick at home and institutionalise only the able-bodied poor, but there proved to be inadequate medical relief and the sick poor had to be accommodated in workhouses or workhouse infirmaries.

Administration of the infirmaries was separated from that of the workhouses only in 1867 under the Metropolitan Poor Act, which also established the Metropolitan Asylums Board to administer hospitals for lunatics, fever and smallpox cases. The workhouse hospitals were not connected with medical education, the bulk of nursing was performed by paupers, and the medical officers had no security of tenure and ordinarily took positions part-time while hoping to develop a private practice. By the end of the 19th century, the dramatic overall increase in this two-tiered, but still limited, formal system was visible. Approximately 39,000 sick were treated in voluntary hospitals (1901 figure) and 100,000 sick treated in Poor Law institutions (1911 figure) (Abel Smith, 1960:51;1964:189). The development from the 1880's of private nursing homes and paybeds in voluntary hospitals reflected and reinforced the increasing use by the middle and upper classes of institutionalised care - 13,000 sick (1911 figure, *ibid*) - but most were still treated at home with an increasing use of private nurses.

In the course of the 19th century a single mode of healing - allopathic, or treatment by opposites - came to dominate all others. It was centrally organised, legitimated by the state and male dominated: 'medical practitioners became the leaders of all other recognized health-care workers' and were successful in their claims to be a 'profession', while the claims of nurses and midwives were less successful. One account of how the professions came to be male-

dominated stresses the already-existing distinction between public and domestic domains and the almost exclusively male nature of the public world of the 19th century, along with patriarchal authority in the domestic domain. Men were thus able to ensure that the occupations which succeeded in their claims to professional status were male ones, supported by the subordinate labour of nurses in hospitals and by wives and servants in households (Stacey,1988:Part One).

These developments were linked with changes in social class structures, the growth of commercialism, and changes within the medical hierarchy, especially in the struggles between hospital consultants and GPs, in which the BMA was an important element. The General Medical Council was established with the 1858 Medical Act and GPs were subsequently represented in the 1886 Medical Act. By the end of the century, a self-conscious occupation had emerged which aimed for control of its work situation and clients and of its own supply and remuneration (see Stacey,1988:78-97). Despite some valiant attempts by women to be part of this profession, only 212 females out of 36,000 registered medical practitioners were to be found in 1901 (Smith in Stacey,ibid). Midwives had been subsumed into the health hierarchy, but in a subordinate role to doctors (see Anne Witz in Walby,1988:74-90).

The roots of nursing as an occupation were clearly visible in the 19th century. The successive reforms of nursing, almost entirely led within the voluntary hospital system, defined nursing in ways that were to prove remarkably resistant to change. Firstly, nursing in the 'public domain' was to be distinguished from nursing as part of the domestic domain. Secondly, its status in the health hierarchy was to be established. Thirdly, its own internal hierarchy was to emerge.

From the outset, nursing reflected the Victorian class structure. Whilst working class women had been increasingly drawn into waged labour by capitalism, middle class women had been subjected to the ideology of domestication. By mid-century the 'spinster' problem and lack of public outlets for middle and upper class women led to the

attempts by Nightingale and others to reform nursing as a respectable occupation for themselves as well as for the 'better' type of working class women. The way in which this was done was through their connections in the male public and political domain. The model of nursing which emerged was deeply constrained by historical circumstance and the medical model (see Stacey,1988:94). There has been a considerable debate about the role of Nightingale and other reformers which turns on the extent to which nurses were instrumental in their own subordination to doctors, or established their independence from medicine. In the event, the model turned out to be deeply patriarchal, hierarchical and class-based: nurses were handmaidens to doctors, upper class women were trained to be leaders (matrons) and there were 'lady-pupils', who paid for their maintenance during training, and probationers, who received free training and maintenance (Abel-Smith,1960:23). These women were supported by a greater number of untrained working class women. All were committed to long hours and low pay and an ethos of 'public service', the latter being influenced by Victorian charitable ideologies and by the religious roots underlying part of the nursing reformist strands.

As noted, more people were cared for in workhouses and asylums than in the voluntary hospitals. In the workhouse hospitals, few trained nurses were employed at all; pauper nurses, often elderly women, remained the core of the workhouse nursing services until the end of the nineteenth century. The few nurses trained in workhouse infirmaries often left for private nursing (Crowther in Stacey,1988:95). In the workhouses, the caring role as opposed to the medical scientific model of nursing predominated. The asylums by contrast were mainly staffed by working class men as the custodial role offered little attraction to upper class women. Towards the end of the 19th century, asylum workers sought reform of their pay and conditions through the trade union movement, which had an effect later on the whole of nursing.

The first half of the 20th century saw some continuity and some change in the 19th century healthcare system. Increasing medical knowledge,

especially in bacteriology, laid the foundations for the development of clinical medicine and the scientific basis for the growth of hi-technology medicine with hospitals increasingly seen as the focal point of healing. The working class gained increased access to GPs through the 1911 National Insurance Act, but the poor and unemployed (notably wives and children) were not covered. The 1929 Act brought the majority of Poor Law hospital provision under the County Boroughs and local authorities which already had responsibility for isolation hospitals, and provided for the establishment of general hospitals. Access was still class-based and limited. The voluntary hospitals were increasingly filled with middle class patients while the former Poor Law hospitals tended for the working class or poor.

Hospital provision continued to expand. At the outbreak of WW1 there were 45,000 beds provided in 800 voluntary hospitals and 120,000 beds in 700 Poor Law hospitals, with 40,000 beds in military, fever and smallpox hospitals. WW1 had the effect of greatly expanding this provision and the number of nurses (Abel-Smith,1964:252-3,281). Private and domestic provision of nursing at home still continued, and the growth in private nursing and convalescent homes was dramatic, reaching 40,000 beds by 1921 (ibid). Private health drew then from the voluntary and municipal sectors just as it draws now from staff trained in the NHS. Prior to the establishment of the NHS in 1948, hospital provision had grown to 130,000 beds in voluntary hospitals (accounting for one third of hospitals and ranging from small cottage hospitals to the great teaching hospitals), 200,000 beds provided by Local Authorities, and a further 200,000 beds in 300 Local Authority Mental hospitals, subject to supervision of the national Board of Control (Guillebaud Committee Report in Clegg and Chester,1957:1-2).

With respect to the health division of labour, partly due to suffrage and women's war work, all legal bars to women entering the professions were removed by a 1919 Act; more women entered the medical profession, although many barriers remained. However, midwives remained subordinate to the male medical profession, despite being accorded state registration in 1902, and nursing became increasingly

stratified. The elite general nursing model, established in the larger voluntary hospitals and the better public general hospitals, continued to be sharply differentiated from that of the older workhouse hospitals and asylums and from nursing care in the domestic domain. Gender and class divisions within the healthcare and nursing hierarchies fed through into different modes of collective organisation. These modes represented two very distinct strands of thought on how to raise the status and conditions of nursing but were also deeply influenced by the 'establishment' in the form of the state, employers and medical profession.

Demands for reform in access to and provision of healthcare had been increasing, fuelled by the extension of the franchise, the growth of trade union membership from the late 19th century, and the Labour Party. These demands were given more urgency by the demand for healthy, and willing, men to fight in the Crimean War and the two World Wars and by the increasing incapacity of the system to function; the interests of politicians, administrators, the medical profession and the middle classes in reform were thus increased. Moreover, given the social, political and economic upheaval in the inter-war years, it has been argued that 'increased state intervention of various kinds (including the organisation of medical care) came to be seen as crucial in the struggle to avert the possible collapse of capitalism itself' (Doyal,1979:176-177).

The healthcare system prior to WW2 was 'administratively chaotic' and 'quite inadequate to meet the medical needs of the British population' (Doyal,1979:175). The increasingly parlous administrative and financial state of the system, with inefficient and expensive administration, general shortage of local government funds during the Depression and insufficient payment from wealthier patients to support the voluntary hospitals, led to an increasingly interventionist role by central government in supervision, financing, and pay determination.

At the time that an expansion in hospital and private healthcare had led to a greatly increased demand for nurses, the system was increasingly unable to pay for them. Wages were also poor. Shortages of nurses, particularly trained nurses, had already been noted in the latter part of the 19th century and these became endemic in the 20th century. With the advent of WW2, these shortages emerged as an important aspect of the economic and political rationale for reform of the health system:

while a peacetime government could, within limits, disclaim responsibility for the nursing shortage which faced the voluntary hospitals and local authorities, and reacted unfavourably on the civilian sick, the outbreak of war made the problems of nursing more of a national responsibility (Abel-Smith, 1960:161).

Trade unions also played a strong role in campaigning for better pay to improve nurse recruitment and retention and for better healthcare provision.

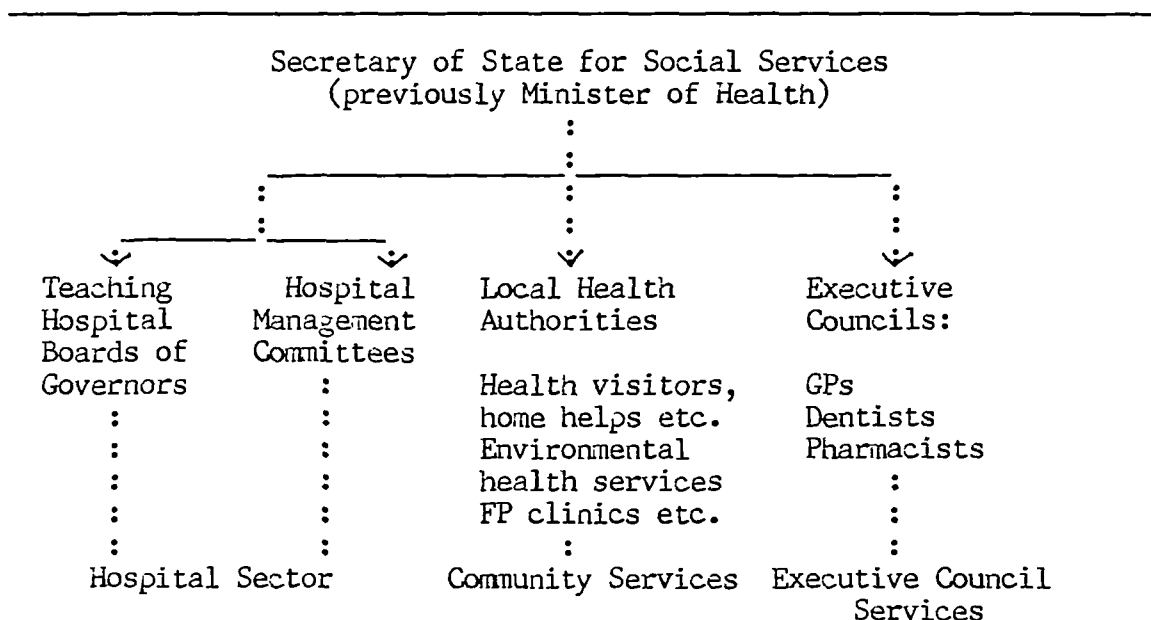
The Beveridge Plan of 1942 for the creation of a welfare state, based in part on Keynes' reformist economic vision, became a central part of the re-building of Britain after the War. The report included plans for a social security system, family allowances and a national health service, and demonstrated a commitment to economic policies designed to ensure full employment. Much of this built on demands that had been put forward by the labour movement for decades. However, if the plans appeared to be a type of settlement between labour and capital they also appeared, at least initially, to be formulated and then operationalised in a way that offered many benefits and relatively few costs to capital [1]. With particular respect to the NHS Act of 1946 and the subsequent establishment and operation of the NHS in 1948, it quickly became apparent that, despite representing a real improvement in medical care for much of the population, that same population, including most of the workers in the NHS, were to be excluded from any real control of it. Moreover, despite the principle

[1] See, for example, Gough, 1979:75-101, on funding of the welfare state.

of 'universality', access was to remain uneven (see Black Report, in Townsend & Davidson, 1980/1982). Benefits accrued to capital directly through the profit opportunities offered by the NHS and, indirectly, through the wider role of the NHS in improving the health of workers and in maintaining economic, social and political stability after the war.

The new NHS structure (see Figure 2.1) was determined by the outcome of negotiations between the state and various establishment groups

FIGURE 2.1 THE NHS 1948-1974



SOURCE: Based on Doyal, 1979:181

including the voluntary hospitals, former approved societies and the leaders of the medical profession - as Stacey has put it, 'by an administrative and political elite of men working with the medical elite...mostly men drawn from the upper middle class' (1988:123).

The ambitions of doctors expressed through the BMA to retain clinical freedom and economic security without salaried status, and the insistence of the consultants on retaining the private sector, were successful and influential in the new system. The tripartite system

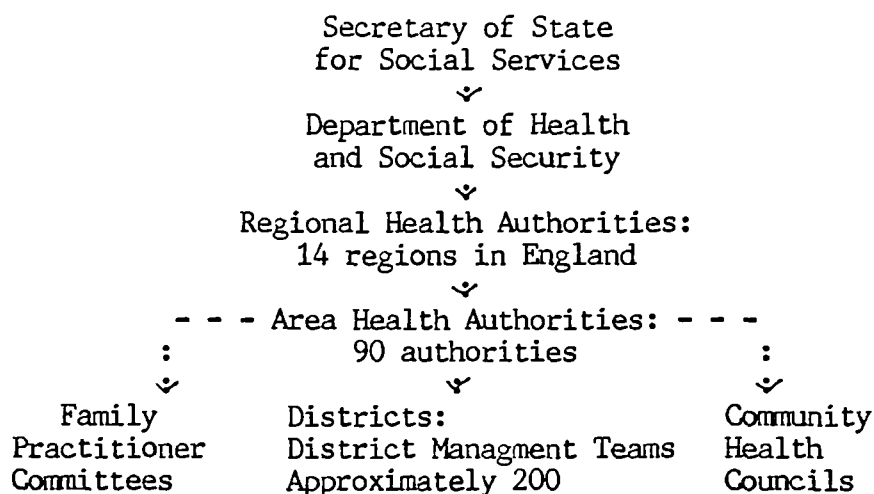
particularly benefited the consultants who, unlike the GPs, were in the end prepared to accept salaried status in the hospitals because of all the concessions they were able to obtain. Hospitals were removed from local authority control and put under regional hospital boards and Hospital Management Committees (HMCs) on which consultants had a high level of representation. The teaching hospitals retained their independent status whilst obtaining NHS funds and consultants were therefore able to maintain a high degree of control over medical advance and practice. Consultants could also choose to hold part-time contracts and thus to combine a regular NHS income with private practice, particularly through the use of NHS pay or amenity beds.

The hospital sector thus became dominant in the new NHS, followed by the executive council sector which provided primary medical care. The lack of resources awarded to the local authority sector, which included environmental health services, midwives, health visitors, home helps and district nurses, and the failure to provide an industrial health service has been called the 'final nail in the coffin of preventive medicine...[reflecting] the fact that these caring and background services offered the least scope for tangible profitability' (Doyal, 1979:182).

Within the hospital sector, hi-technology and acute areas attracted more resources than those dealing with the chronic sick, and have continued to do so despite demographic change and a shift in the pattern of disease from acute illness towards chronic problems requiring caring rather than curing. It is an open question, however, whether these latter changes in demand for healthcare now present a challenge to the initial benefits perceived by capital in the NHS, particularly inasmuch as they represent an increasing demand by 'non-productive' sections of the population.

An initial response to the above developments, and the first of a number of attempts to delimit the power of the medical profession, was the reorganisation of 1974 (see Figure 2.2). This was designed to increase central control and managerial efficiency and therefore cost

FIGURE 2.2 THE POST-1974 NHS



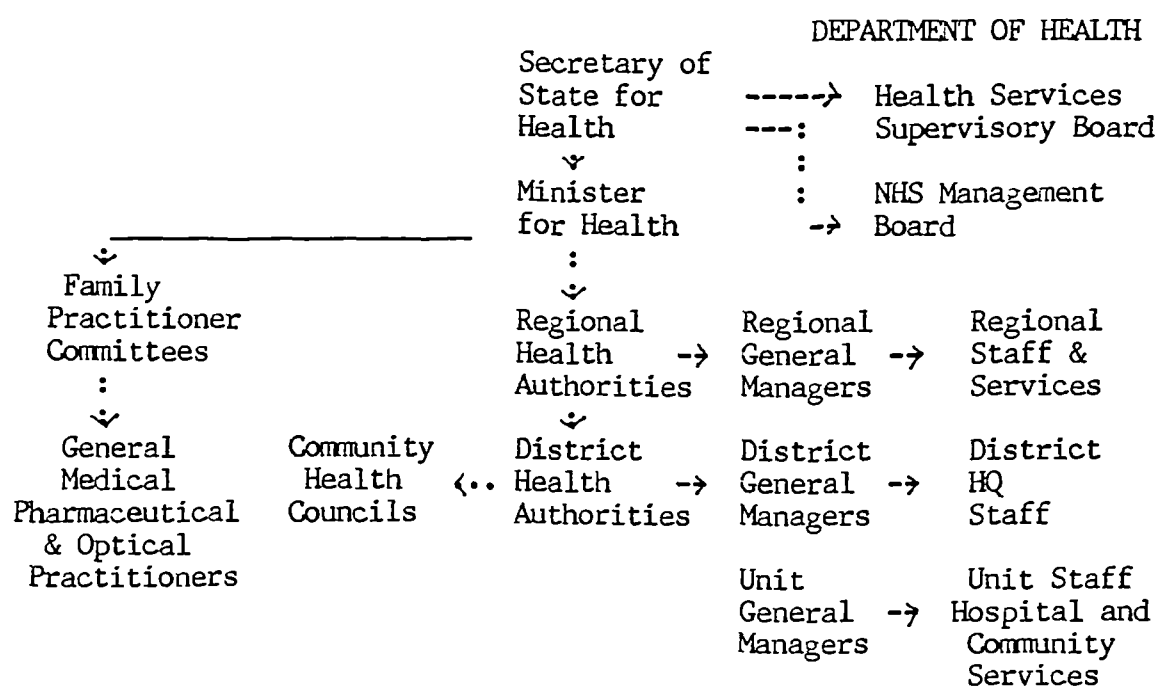
SOURCE: Based on Doyal, 1979:184

efficiency. The reorganisation did not substantially alter the curative, hierarchical, 'expert-led' nature of the NHS nor limitations in access to it. The concerns of healthworkers and patients still remained largely excluded, despite the formation of Community Health Councils (CHCs). It has thus been argued for the period up to the 1980's that 'the priorities of the NHS have tended, throughout its history, to be defined in terms of the wider interests of capital rather than reflecting the real needs of patients' (Doyal, 1979:186) though these interests may often be seen to be contradictory and conflicting. Other accounts have stressed the role of the medical profession itself in limiting change (see Allsop and Levitt in Stacey, 1988:128) though this begs the question of class loyalties.

Reform in the organisational and managerial structure of the NHS has proceeded at breakneck speed from 1981 onwards, with the introduction of performance indicators, the pay review process, compulsory competitive tendering for hospital support services and the abolition of the area tier of organisation. This process culminated in the changes resulting from the Griffiths Report (NHS Management Inquiry, 1983), which have brought in the ethos of general management, the internal market and a greater degree of interaction with the

private sector. Figure 2.3 illustrates the organisational structure of the NHS (English) circa 1988, which reflects the abolition of the 'area' tier of Health Authorities and the creation of a Health Services Supervisory Board and an NHS Management Board. These bodies were both created on the recommendation of Griffiths, were located within the DoH and chaired by the Secretary of State. Their purpose was to set overall objectives and strategy, and oversee implementation. The Griffiths Report also resulted in the substitution of individual chief executives (known as general managers) for the prior system of consensus management teams.

FIGURE 2.3 OUTLINE ORGANISATIONAL STRUCTURE OF ENGLISH NHS 1988

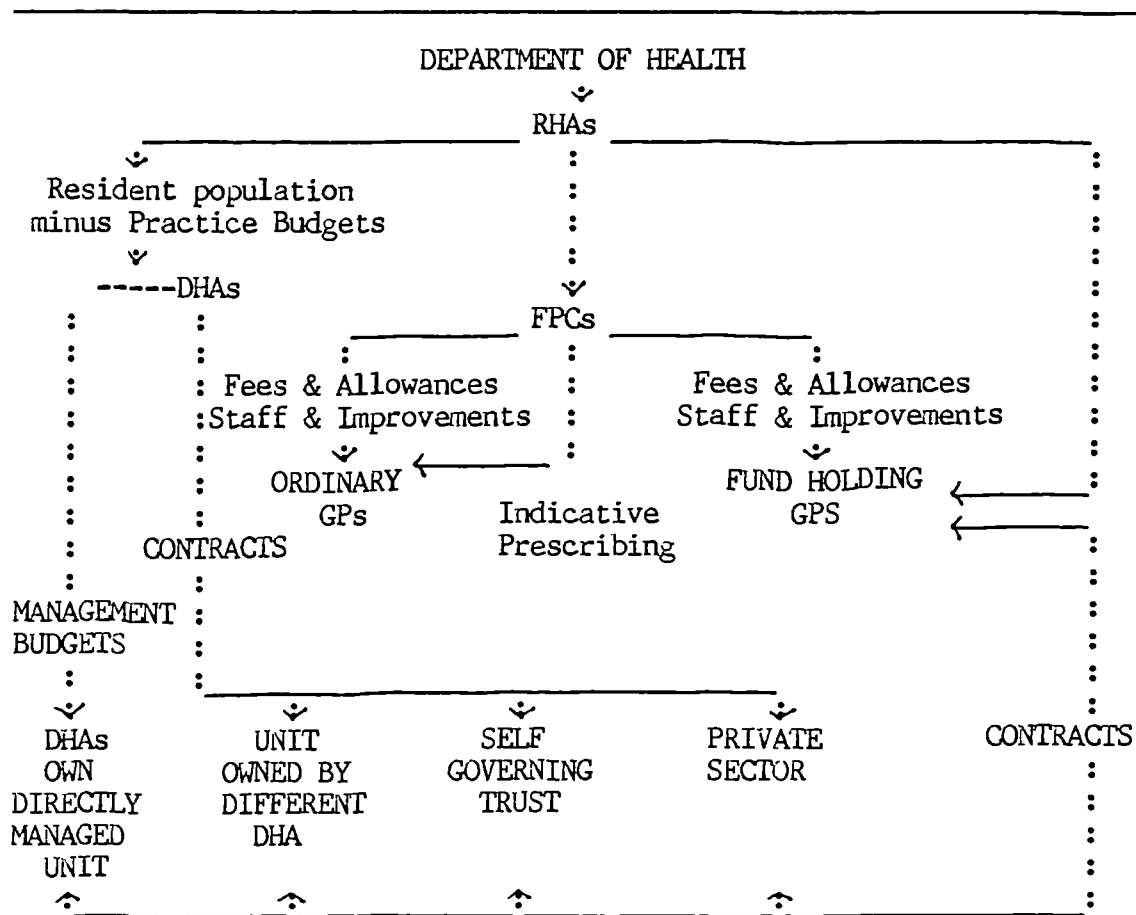


SOURCE: Based on Harrison et al,1990:168

The changes proposed in the White Paper, Working for Patients (DoH,1989) and enacted in 1990 are shown in Figure 2.4. As Harrison et al note, the 'intellectual basis...is the assumption that a system of internal markets, in which NHS health care institutions compete with each other, will produce both greater efficiency and greater responsiveness to users' (1990:169). This has entailed the separation of 'purchasers' and 'providers', further membership changes in Health

Authorities, and 'fund-holding' GPs. The most controversial of the changes is the creation of 'Self-Governing Trusts' (SGTs) and these were overwhelmingly seen by trade unionists in interviews as an unambiguous move towards privatisation and a deterioration in health service workers' terms and conditions. The new SGTs have the freedom to move away from national decisions on terms and conditions through the Whitley Council and Pay Review Bodies and to determine their own terms and conditions for workers. These changes of the 1980's form part of the contextual background for changes in nursing pay, grading and training explored in this thesis

FIGURE 2.4 PROPOSED MAJOR NHS FUNDING FLOWS, 1992-1993



SOURCE: Based on Harrison et al, 1990:173

With respect to the division of labour in the new NHS, a 'broadbrush' picture of the modern workforce shows a degree of continuity which attention to changes, especially managerial changes, should not conceal. Although there has been a great rise in the proportion of staff accounted for by professional and technical, and managerial, administrative and clerical categories, the latter particularly since the 1980's, nurses still account for 50% of the workforce. Table 2.1

TABLE 2.1 NURSING STAFF AND OTHER HEALTH AND PERSONAL SOCIAL SERVICES EMPLOYMENT: ENGLAND 1990 (WTEs)

Health Service staff and practitioners	
Directly employed staff	796,359
Of which:	
Hospital Medical and Dental staff	42,870
Community Health Medical & Dental staff	3,978
<hr/>	
Nursing staff total	378,300
(of which):	
Administrative	1,830
Centrally based services	2,024
Blood transfusion services	1,274
Hospital staff	328,056
Primary health care services	32,599
Health visitor students	812
Agency nursing staff	6,705
<hr/>	
Midwifery staff total	23,976
(of which):	
Administrative staff	86
Hospital staff	19,689
Community health services	4,201
Agency midwives	-
<hr/>	
Professional & Technical staff	83,987
Works professional staff	3,902
Maintenance staff	16,019
Administrative & Clerical staff	129,716
Ambulance officers & control	2,786
Ambulancemen/women	15,345
Ancillary staff	95,689
<hr/>	
Family Health Services:	
Practitioners total	49,434
<hr/>	
Local authority social services staff total	240,342

SOURCE: Compiled from Health & Personal Social Services Statistics for England, 1992 edition.

shows the occupational make-up of the NHS in 1990.

It has been argued that a formalised, curative health system came to dominate in the 20th century, largely at the expense of measures addressing the productive system, preventive health measures and those based on care in the community or at home [2]. The health division of labour reflected and reinforced this system. The modern nursing workforce has thus been deeply influenced by the wider productive system, the form of healthcare, the medical division of labour, and the domestic division of labour. A concern of this thesis is to explore the extent to which changes have modified this legacy.

THE DEVELOPMENT OF REPRESENTATIVE ORGANISATIONS

The previous section emphasised the influence of the wider political economy of health on the health division of labour. The development of the modern nursing workforce could thus be seen to be circumscribed by wider factors. Another part of the history of nursing lies in the attempts by nurses to affect their own work and working conditions through collective representation and organisation. These activities were similarly circumscribed. Nonetheless, a complex set of interrelationships developed against which changes in nurses' pay, training and grading can be more clearly plotted.

The differences between professional associations and trade unions in nursing and the health service have been historically specific and the two forms have reacted upon each other. Both may appear very similar at times; individual associations or trade unions may equally be occupationally-based, concerned with pay and professional issues such as training, qualification and grading and status. They may or may not affiliate to the TUC or Labour Party, adopt non-militant positions, use political lobbying, seek national pay determination and bargaining, have local representative officials. Associations may also

[2] See also Doyal, 1979; Kinnersley, 1973; Black Report, 1982, on the continuing importance of the effects of the productive system on health, and on the still-pertinent effects of social class.

be subsumed within unions or become unions. However, differences between nursing representative organisations have been important.

The early history of nursing professional associations and trade union organisation shows the strong influence of political, economic and sociological factors outlined in the previous section. Different forms of representation initially reflected the divisions between different health services, notably the voluntary hospitals, Poor Law and later, municipal hospitals, and asylums, later mental hospitals. Patterns of representation also reflected the health division of labour and differential class access to healthcare.

General nurses in the voluntary hospitals followed a model based on professional patterns, which stressed 'vocation, selflessness and dedication' (Stacey,1988:109). In this they were strongly influenced by the male medical profession model and their position in the health hierarchy. The early crusaders for nursing reform had been upper or middle class women attempting to create a role for themselves outside the domestic domain, and the subsequent nursing hierarchy reflected domestic, religious and military hierarchies. The influence in general nursing therefore was from top to bottom, with the reformers and matrons in a position of great power. There was initially considerable competition amongst the 'ladies' to form and lead an association to gain more professional recognition, and considerable splits amongst the establishment over how to deal with them.

Abel-Smith (1960) has chronicled the early development of nursing associations. By the early 1900's a wide variety of such associations had arisen. However, the British Nurses' Association, a self-selected group of women, had a disproportionate influence. This association had been formed by Mrs Bedford Fenwick, a 'very blue Tory' (p131) in the late 1880's as a 'union of nurses for professional objects' and contained the 'elite of the profession' (p69). The constitution and membership gave strong weight to doctors and the London teaching hospital matrons. The BNA started a register on which, up to 1889,

lady-pupils who had received only one year of training were admitted. Thereafter, future applicants would be required to have three years' training and the BNA also sought national standards of training and examinations. The aim to professionalise nursing was clear. Although training schools in the late 19th century issued certificates, quality varied. Moreover, it seemed necessary to 'draw a firm line between those who were fitted to practise as nurses and those who were not'. The 'militant lady-pupils' (p61) saw a need to intensify the training and make it more intellectual and to draw away from the rather practical course Nightingale had instituted.

All these ambitions were opposed in various ways by different factions. Nightingale was opposed to registration, believing that the professional competence and personal qualities of a nurse could not be judged via an examination and that a year's training was sufficient. A number of hospital administrators were deeply opposed to any measure which would narrow the field of recruitment, especially one as small as that of the upper classes which the ladies envisaged. The cost savings that had already been achieved through a cheap student labour force had to be set against potentially increased costs of training, and possible shortages. Particular concern attached to the possibility that salaries would be raised through the abolition of the cheap labour provided by unqualified nurses, and the potential power of a profession to restrict entry and control standards in the hospitals.

A split could also be seen between doctors in the London teaching hospitals (BMA), who viewed the idea of a more skilled handmaiden with some favour, and humbler GPs in the provinces (IMPA) who appeared to feel threatened by the possibility of rivalry from registered nurses. A fascinating battle between Mrs Bedford Fenwick and Nightingale ensued, in which both sides drew support from personal connections in the medical profession, hospital administrations and parliament. Many matrons and nurses at this time were opposed to registration. The battle for registration gained impetus from the registration of teachers (1899) and then the Midwives Act of 1902. In the early 1900's several Bills were drawn up and rejected for nursing

registration, with the government appearing to be split between differing political loyalties. A Select Committee in 1905 recommended registration, but also recommended a new type of nurse with a shorter training. This latter recommendation was eventually taken up in 1943.

The balance of political and economic interests was finally altered by the First World War. The introduction of more untrained women to work in the hospitals united the upper class women in a desire for registration, public sympathy for the nurses' case increased and women won the vote. Also, the first of many subsequent shortages of nurses in the 20th century arose. Perhaps most importantly, the major political parties in the Commons had a more basic fear:

If you force nurses [by opposing registration] to form trade unions in order to secure that which they regard, and rightly regard, as a measure of justice and a right to them, you will simply throw them into the arms of the Labour Party (Lord Amthill quoted in Abel-Smith, 1960:93).

Thereafter, registration was a political certainty. A battle then ensued between the BNA and the new College of Nursing to become the major voice of the nursing profession. The College had been founded in 1916 on an initiative between matrons and doctors, was against striking, and was strongly backed by Peers who were heavily represented on the teaching hospital boards. The battle was won by the College, which was openly allied with hospital managements and was prepared to pay some attention to the staffing needs of the hospitals in the standards it laid down for the profession. A bill was finally introduced by the Minister for Health and was enacted in 1919.

The Register which was created contained supplementary parts for male nurses, mental nurses and paediatric nurses. People without formal training or certification were admitted at the outset, but three years' training was needed thereafter for admission (the first state examination took place in 1925). A Council was established to oversee the register and approve training schools. The General Nursing Council was appointed by the Minister and consisted of members of the political, medical, hospital and nursing establishment, and

disproportionately represented the voluntary sector. When the Council attempted to lay down a requirement for one year's prior training for admission to the Register, Parliament intervened to stop it so doing. In all these arrangements, untrained nurses or nurses with incomplete training were completely excluded from the future of the 'profession'. In addition, many who were qualified to enter for registration did not do so.

Many more nurses, registered or unregistered, had had little to do with this process as they were largely unrepresented in these formal structures or within the nursing associations themselves. The College of Nursing quickly became the dominant nursing association, despite some competition from the BNA and the British College of Nurses, formed in 1926 by the Fenwicks. The latter claimed to be an organisation controlled by nurses as opposed to the College of Nursing which had senior lay and medical establishment figures on its council. Many nurses were excluded from College of Nursing membership; student nurses were not admitted until 1926 (Carpenter, 1988:178), male nurses not until 1960 (Salvage, 1985:113) and unqualified nurses were excluded by definition. The College received its Royal Charter in 1928, becoming the Royal College of Nursing (RCN) with royal patrons and a large list of titled non-nurses as Vice Presidents. The battle for members and for 'professionalisation', however, was to continue.

The main competition to the early nursing associations and then the dominant RCN, was the trade union movement. In the late 19th century, 'New Unionism' had extended the base of the trade union movement beyond privileged groups of skilled workers. Early attempts by asylum workers to form a trade union did not prove successful, but in 1910-11 the National Asylum Workers' Union (NAWU), later to become the Confederation of Health Service Employees (COHSE), was launched. This was largely as a result of the professional association of the time, the Asylum Workers' Association (AWA), failing to secure acceptable terms and conditions for the bulk of asylum workers. The AWA had been formed in 1895 by the medical and lay establishment, was based on the

BNA model (which refused to take male mental nurses), and was dominated by the elite of medical superintendents.

The conditions for both asylum workers and 'patients' in the 19th and early 20th century have been movingly recounted, along with the fluctuating fortunes of the new union by Mick Carpenter (1988:pp19-136). The historical roots of the healthcare system are again significant. At the end of the 19th century the asylums had largely become a means of controlling a permanently captive population at the least possible expense on local rates. Asylum nurses' and attendants' wages were at the bottom of the wage league, hours long and conditions poor. Nursing was regarded more as a job of last resort rather than as a vocation, particularly as in the early years the job consisted more of security and control rather than of any recognisable 'nursing' tasks. The nurses were working class and geographically and socially isolated and therefore formed a community of interests. Doctors were few and far between, so the nurses had more responsibility. Female nurses were brought in as cheap labour in the late 19th century and the model of general nursing began to take root for both the male and female staffs, particularly with the influx of general nurses as matrons from 1900. The bulk of nurses, both male and female, however, received little recognition in terms of pay and conditions for qualifications and many were unqualified.

The NAWU was formed through the nurses' and attendants' identification with the rising working-class labour movement in 1910-13 and accompanying upsurge of militancy, though the NAWU was not from the outset a particularly militant body. After failing to gain improvements through legislation, however, the union shifted to more local activism and eventually sought affiliation to the Labour Party and then the TUC to gain wider support. The higher turnover of female nurses, along with the more professional identifications of some of them and the barriers to their participation in the union were early problems, but women were highly influential nonetheless in the gains made after WW1 through local activism.

The period 1914-1920 saw a doubling in trade union membership generally, from 4 to 8 million. The increase in trade union membership and militancy during the First World War gave rise to the idea of government as 'model employer'; the coalition government was anxious to avoid the spread of labour unrest, particularly in the munitions industries. This led to the setting up of arbitration machinery, independent tribunals for the civil service, and finally the Whitley Reports of 1917 and encouragement to private employers to set up national bargaining machinery over pay and conditions and to channel conflict. However, this had little immediate impact for nurses, given the general hostility of Asylum Boards. A period of militant action by the nurses ensued, along with a considerable growth in NAWU membership - from 12,000 in 1918 to an inter-war peak of 18,000 in 1920. The NAWU adopted a National Programme, and sought affiliation to the TUC in 1918. The asylum employers then sought help from the Ministry of Labour to set up an 'Industrial Council' along Whitley lines rather than face industrial action from NAWU. A conciliation committee was duly established and the NAWU had succeeded in obtaining recognition and significant concessions from 'one of the most reactionary and authoritarian groups of employers in the country' (Carpenter, 1988:80-150).

The subsequent years, 1920-31, saw a sharp economic downturn, a decrease in public expenditure, and a loss of strength and membership for the NAWU (12,500 by 1930). Authorities failed to observe the Joint Conciliation Committee awards in full and as the tide turned in their favour, began to make wage reductions. The union responded by seeking local concessions where it could, developing the 'friendly society' side of its activities and shifting its emphasis from pay and conditions to questions of status and professionalism. Reforms were taking place, albeit in a sporadic fashion and much influenced by the political colours of the government of the day. Attempts were made to transform the custodial asylums into curative mental hospitals, culminating in the 1930 Act passed by the Labour government. NAWU began to see the possible complementarity of 'trade unionism' and 'professionalism' (ibid:98). Improvements in wages and conditions

were achieved in the late 1920's, with membership rising once again, despite an all-time low in 1926, the year of the General Strike.

The NAWU changed its name in 1931 to the Mental Hospitals and Institutional Workers' Union (MHIWU) but economic slump and high unemployment undermined its activity on hours and wages. By 1934, however, its membership was again rising and wage cuts had been restored. At this stage the chronic shortage of female nurses was again coming to the fore. This was exacerbated by the growth in demand caused by the growth in the public health service, the competition of alternative factory and office work for women, and, above all, the continuing poor pay, hours and conditions which failed to compensate for the former. Proportionately fewer women were joining the union at this stage, probably due in part to the growing domination of general nurse matrons on the female side of mental nursing so the union had limited success in remedying the problem, despite a commitment to equal pay. The union also failed to address the problem of lack of female participation in its structures. The shortages persisted well up to WW2 and the state eventually had to take a direct role in pay determination for this group, as for other groups of nurses and NHS staff. With the creation of the NHS and a new pay determination system, the MHIWU amalgamated with the Hospitals and Welfare Services Union (1946) to form COHSE and a trend away from sectional interest to health service unionism was started.

Some progress was also made by trade unions in poor law institutions and hospitals, which shared some of the characteristics of asylums; both were larger institutions than the voluntary hospitals, nurses tended to be working class, conditions were much worse than in the voluntary hospitals, and there was the possibility of attracting extra money to pay higher salaries (Abel-Smith,1960:132). However, nurses in the poor law hospitals had other characteristics that also hampered nurses in the voluntary sector from joining trade unions. The general nursing model had been imported at the top of the hierarchy and through the personal influence of the matrons, who were frequently antagonistic to trade unionism, as were the hospital administrators,

and encouraged professional association membership instead. This model implied a tradition of selfless devotion to the sick, opposition to strike action on the grounds it would harm the patient, and, to some extent, aspirations of social elevation. The influence of 'professionalism' thus tended to divide the nursing workforce here as elsewhere. Maggs argues that there was a degree of managerial strategy in incorporating working class nurses into the hierarchical, and ideological, structures of general nursing (Carpenter, 1988:166).

A number of different unions and associations were formed in this sector which attempted to organise nurses, but there was less success than in the asylums. In 1918 the Poor Law Workers' Trade Union (PLWTU) was established for all ranks in the service; around this time, the Professional Union of Trained Nurses was also founded, with a no-strike clause, and the Poor Law Officers' Association also formed a nursing section.

The PLWTU started as an industrial union but, with the 1929 Act and the break up of the Poor Law and transference of its activities to local authorities, no industry survived for it to represent. It survived in the 1930's by increasingly becoming a specialised health service union. The growth of nursing staff in this sector at the end of the 19th century had not led to any general improvement in pay or conditions. Pauper nurses were also the main form of nursing staff, as has been noted. In the early 20th century the hiring of paid nursing staff accelerated along with the practice of hiring trained nurses as supervisors. However, by the end of WW1 this process had been slow. Nurses tended to be working class and regarded as poor relations by nurses in the voluntary hospitals, and those that could left for the private sector after training. Many unqualified women filled the gaps. Until WW2, pay actually had to be higher in this sector than in the voluntary sector, in part to attract nurses at all.

Given the relative weakness of trade unionism in this sector, no permanent national bargaining machinery was set up - the militancy which had achieved this for the asylums was not there in sufficient

measure to gain employer acceptance. Endemic shortages of nurses in this, as in the voluntary sector, were perhaps the inevitable outcome of a resultant failure to raise pay and conditions to levels sufficient to recruit and retain.

The survival of trade unionism in this sector of nursing, as in asylum nursing, nonetheless had an important, if indirect, influence on pay and conditions. As Abel-Smith put it:

the real challenge to the position of the College of Nursing in the twenties came from the growth of trade unionism among the nurses and the possible association of organisations opposed to the College with the wider Labour movement. The more militant spirit among the working nurses arose out of widespread dissatisfaction with pay and conditions of work (1960:134).

By threatening to compete with the RCN, trade unions tended to produce a shift in attitudes over pay and conditions from the RCN, employers and, in conjunction with shortages and funding problems, the state.

It is against this background that the 1919 Nurse Registration Act and the formation and subsequent development of the RCN must be considered. Although many matrons were opposed to trade unionism, some did join the PLWTU and it then became considerably easier for other nurses to join without fear of victimisation. The tendency in the first half of the 20th century, probably spurred by registration with the insistence on training and living in, was for younger, single women to replace older widows and married women (Abel-Smith, 1960:118). These younger probationer nurses had more options in the external labour market and were beginning to rebel against pay, conditions and harsh discipline in the hospitals. In 1919, the Nursing Times (later to become the RCN's official magazine) had warned the College: 'it is obvious that if professional societies work too slowly, the more impatient spirits will join something that will secure them benefits' (in Carpenter, 1988:178). The RCN subsequently established a Salaries Committee, which published recommended pay scales from 1919, and set up a Student Nurses' Association (1926). However, the trade union movement in general was in retreat in the 1920's and these moves were largely cosmetic and did little to improve pay or conditions.

The 1930's saw a renewal of the movement to unionise nurses. The TUC exhibited a growing desire to assist in the recruitment of more women workers, and growing shortages, press attention and the Lancet Commission's report in 1932 criticising traditional nursing institutions all played a role in raising trade unions' profile. However, there were too many unions competing for the nurses. In 1937, the TUC formed a National Advisory Committee for the Nursing Profession and established a new Nurses' Charter which included plans for national pay determination. The National Union of County Officers (NUCO) as the PLWTU had then become, joined the TUC in 1935. Health worker numbers were expanding rapidly and by 1939 its membership had increased to 13,000. It became a campaigning, even militant, union, yet with a strong professional ethos. By 1939 the Guild of Nurses within the NUCO became its most active and successful group, attracting male nurses, student nurses, assistant nurses or untrained nurses who were excluded by the RCN, and obtaining improvements.

The numerous Committees and Commissions that reported in the 1930's and during WW2 on the 'nursing problem' also testified to a growing public awareness of nursing shortages and public pressure to resolve them. However, at the same time, such bodies could be viewed as largely holding operations by the state, employers and medical hierarchy to avoid confronting the central issue. As with the battle for registration prior to 1919, there was the appearance of disunity. Thus, despite:

the widespread dissatisfaction over pay, conditions of service and standards of education which were seen to combine in depressing recruitment and encouraging industrial militancy by nurses...the remedies proposed by the various factions within the system were vulnerable either to the limited perspective of their advocates or to the combined weight of their opponents (Dingwall et al,1988:98)

Registration and the attempt to 'professionalise' had borne little fruit in terms of pay and conditions, although it had raised the perceived need for trained nurses and thus perceptions of shortages of trained nurses. Poor pay and conditions created high turnover, outweighing the cost advantages of cheap student labour, and employers

increasingly substituted untrained or semi-trained nursing labour. Inaction by the state, employers and medical hierarchy meant that the shortages persisted through the Second World War and increased political pressure for reform; in this way, nursing shortages were themselves an important part of the pressure for a new healthcare system.

PAY DETERMINATION

Immediately prior to World War Two, the healthcare system was in a state of financial and administrative chaos. Nursing shortages were endemic and the fragmented, mainly local, system of pay determination was increasingly identified as an important factor in this. At this point, despite important advances, the great majority of nurses were 'outside the scope of collective bargaining' (Clegg & Chester, 1957:4). Pay levels reflected hospital ownership, local labour market conditions, medical specialities, hospital conditions, and the extent of union organisation. Thus, voluntary hospitals generally paid lower rates than municipal hospitals because their conditions were deemed to be more pleasant or more suitable for the socially more elevated nurses that congregated there. Likewise, children's nurses were paid less than fever nurses, and pay variations also existed between different localities and across different grades. However, despite this 'flexibility', 'there was no doubt that, by and large, hospital work was badly paid' (Clegg & Chester, 1957:5) and for nurses 'both pay and conditions of work were unattractive to prospective recruits' (Abel-Smith, 1960:161).

There was strong pressure from the labour movement for reform and health service unionism was beginning to reassert itself and attempt to coordinate its activities. A desire for a national, integrated health service and for national pay determination for its workers had long been part of the labour movement's agenda. Two Bills were drafted by the TUC seeking further improvements in nursing pay and conditions, but both of these failed due, in part, to the Athlone Committee which had been set up through RCN intervention to head off the growing

movement for trade unionism amongst nurses. When Athlone reported in 1939, many of its recommendations closely followed the TUC Charter, including that for the formation of a national negotiating body. The cost implications, however, were particularly unwelcome to the voluntary hospitals whose financial position was deteriorating. National salary scales and superannuation arrangements would have obliged them to match the higher standards in the municipal hospitals (Dingwall,1988:103). The government also rejected the suggestion that they should interfere in the setting of wages for professionals. As Carpenter has put it, 'after all, the committee had served its purpose. Just enough MPs had been persuaded to vote against the Limitations of Hours Bill 1937, the reputation of the College had been rescued and militancy among nurses was finally beginning to die down' (1988:219). World War Two then shifted the focus elsewhere and the work of the Athlone Committee was halted.

The Emergency Medical Service was created in 1939 and required all designated hospitals (some 2,400 of the 3,000 total) to receive casualties, thus bringing both voluntary and municipal hospitals into a regional scheme of planning, with staffing by full-time salaried officials. The voluntary hospitals were given exchequer subsidies and these rapidly became an indispensable source of income. In order to effect a re-direction of nurses within the emergency service, national pay scales were essential (Webster in Dingwall,1988:104), and an increase in pay was also essential. In 1941, the government imposed standard rates somewhat higher than those pertaining previously in the municipal hospitals, and substantially more generous than those in the voluntary sector. The cost implications thus deepened the government's involvement in funding the hospital service and strengthened the impetus towards central state provision of health services.

The imposition of standard rates was only intended as a temporary measure pending the establishment of a longer-term mechanism for pay determination. The government set up a committee chaired by Lord Rushcliffe in late 1941, modelled on the Athlone Report

recommendations, and the Committee gradually broadened its terms of reference to include the determination of conditions as well as of pay. Rushcliffe comprised an employers' panel and an employee's panel.

Paradoxically, considering its long-standing opposition to state involvement in nurses' pay negotiations, the Royal College of Nursing was allocated more seats on the staff side than any other individual organisation. This was an important precedent, since the Rushcliffe arrangements were perpetuated almost unchanged in the NHS Whitley Council (Dingwall, 1988:104-5).

Following the 1946 NHS Act and the establishment of the NHS in 1948, the Whitley system was set up. Though the Whitley system appeared to be a major advance for industrial relations in general and the trade unions in the role it enabled for 'free' collective bargaining, the system was circumscribed by a number of factors. The evidence suggests that the state was not neutral in the system that emerged nor in its attitude to the role that trade unions played in it. The government had previously been ambiguous on trade union rights and had failed to recognise that unions faced many more obstacles than professional associations, which were generally favoured by management. In the new NHS, Bevan created very little role for trade unionists or nurses below the rank of matron on the Regional Hospital Boards, and effectively excluded them from Hospital Management Committees through a Circular issued in 1949.

The structure of the Whitley system for nurses and midwives consisted, as for other NHS groups, in a General Council and a specialised Functional Council comprised of Staff Sides and Management Sides in which negotiations over pay and conditions were to take place. The professional associations had been disproportionately represented on the Staff Side in the Rushcliffe Committee, and this continued to be the case in the Whitley system. Abel-Smith pointed out that the membership claimed by the RCN included many non-active nurses and membership of the staff side of Whitley therefore did not follow the proportions of active nurses that were attached to the different organisations (1960:193). NUCO had renamed itself the HSWU in 1943 and combined forces with the MHIWU, becoming COHSE on 1 January 1946, with a combined membership of 40,000. The RCN in 1946 had a

membership of 41,500, with membership of its associated Student Nurses' Association standing at 12,700 (Carpenter,1988:228,242). However, it has also been noted that the unions were not in a position to mount a challenge to this distribution of seats as NALGO was still outside the TUC, and the affiliated organisations were disunited (ibid:266). The presence of both trade union and professional association representatives was early seen as a possible source of conflict and division on the Staff Side (Clegg & Chester, 1957:19).

In contrast to Staff Side divisions, the Management Side appeared relatively united but still posed a problem for the successful operation of the Whitley system. The purse strings were held by the government, and the representatives of regional boards, the 'legal' employers of nurses, and of the hospital management committees were appointed directly by the government. Lower levels of management who actually dealt with most day-to-day management were excluded entirely. In this respect, the Management Side was heavily dominated by the government, with a much wider agenda than day-to-day provision of health services and the 'fair' or 'economic' remuneration of nurses. The problem in part, as Lord McCarthy later put it, was that the Side was divided between 'employers who do not pay and paymasters who do not employ' (McCarthy,1976). Perhaps most pertinently, local managers at the 'sharp' end of employment decisions were not represented at all. On both sides, inadequate representation may have limited the capacity of the machinery to improve nurses' pay and therefore resolve shortages.

The intention of government to constitute and use the pay machinery in a 'positive' way was also in doubt. The post-WW2 Labour government was confronted not only by powerful vested interests within the health system but also by significant economic pressures. From 1948, the government adopted a policy of wage restraint and nurses were certainly not immune from it. Public sector pay was an area where government as employer could have particular effect in containing wages and in providing an example in so doing to the private sector. Because of their history, hierarchical relations, divided

representation and public service ethos, nurses were particularly vulnerable. In this important respect, the 'model' set by successive governments as employer may be seen to have been in some contention with perceptions of its original role in channelling conflict. However, limitations existed on this 'new model' in the form of the need to maintain electoral viability and in the form of the pressure that did arise from nurses, their representatives, and sometimes nursing employers.

The composition of the Staff Side had early consequences. In 1948 COHSE ran a campaign to achieve a minimum wage for student nurses, largely against the long-standing view of the RCN that student status was more important than their pay and conditions. The first militant demonstration of nurses since the 1930's took place shortly before the Nurse and Midwives Council (NMC) met, and students' pay and conditions were improved. The RCN then shifted ground, but COHSE did not benefit in terms of recruitment of general nurses to the union because 'the victory was not in the final analysis seen as belonging to COHSE but to the staff side of the Whitley Council as a whole, whose secretary was Frances Goodall of the RCN' (Carpenter, 1988:273). The pattern of benefits from trade union activism accruing to the professional associations was to continue; for example, in the late 1950's nurses gained from the efforts of ancillary workers to obtain a 44-hour week. The contrast between the NMC, dominated by professional associations, and the ancillary workers' council, dominated by trade unions, again failed to reap the rewards for trade union membership that might have been expected. Some commentators have ascribed a partisan role to government in this. According to Abel-Smith, the professional organizations were losing ground to the trade unions before the Second World War and nurses were getting more militant. Government then intervened 'by its choice of representatives on official committees, by its ratifications and financial support of the decisions of those committees' and strengthened the position of the professional associations. The trade unions thus became recognized partners in the negotiating process but the benefits from the tougher methods of negotiation that characterized the trade unions accrued to the

professional associations as well as to the trade unions. Indeed, as the professional associations held the majority of the seats on the Whitley Council:

they may have gained more from the trade unions' toughness than the trade unions themselves...for the loss of support for the existing machinery might well have led to larger recruitment of nurses by trade unions and the reconstitution of the negotiating machinery with the trade unions playing a larger role. To some extent the skill of the trade unions in collective bargaining promoted the status and membership of the Royal College of Nursing (1960:208).

The early operation of the Whitley system also led to suggestions that the system contained an in-built advantage to government in 'delaying' or 'depoliticising' settlements, particularly through the frequent recourse to arbitration which came to characterise its operations. Negotiations for unqualified and more specialist grades of nurses 'dragged on' for several years after the setting up of the NMC before a settlement was made and it has been suggested by Carpenter that 'the delays seemed to be deliberate government tactics' as nursing staff 'appeared to be snarled up in the employers' desire to pursue the government's "wage restraint" policy' (1988:275). Clegg & Chester also noted the possible willingness of management to take certain claims to arbitration as this put responsibility for wage increases, or failure to make them, at times of general wage restraint, one step removed from the government (1957:94). In this respect, the machinery may have succeeded to some extent in channelling conflict or securing political cushioning.

However, the delays incurred in this system may in themselves have been a source of irritation and the poor pay outcomes for nurses almost certainly were. In 1950, the wage freeze, and the TUC's withdrawal of support for it, in part foreshadowed the electoral defeat of the Labour government by the Conservatives in 1951. Nurses had achieved a once-and-for-all uplift in pay and conditions with the establishment of the NHS, but a pattern of pay determination had been set in motion which would persist for several decades. This is now briefly reviewed, and evaluated in more detail in subsequent chapters.

The 1950's and early 1960's saw a retrenchment in nursing pay and nursing trade unionism that, with the benefit of hindsight, could be regarded as quite remarkable given the beneficial economic environment of those years. An active policy of grade dilution aided an equally active policy of poor pay settlements for nurses. De facto cash limits were in operation - the £400 million spending limit introduced by the Labour government in 1950 was continued by the Conservatives until 1954 - and these put pressure on negotiators and local employers. The Conservative government thus continued and intensified cost containment policies, further exacerbating nursing shortages. NHS spending declined as a proportion of GDP, only improving marginally after the publication of the Guillebaud Report in 1957 which had largely exonerated the NHS of charges of excessive expenditure. Delays in pay negotiations, the build up of staff resentment, and then arbitration epitomised these years and, combined with different varieties of cash limits and grade dilution, meant that an effective policy of pay restraint was in operation. In this period, trade unions provided little effective resistance: health workers increasingly organised on the basis of 'grade unionism' rather than responding to the 'industrial unionism' COHSE had wanted, and trade unions made little headway in recruiting general nurses. A relatively generous deal was made for nurses in 1959, illustrating the electoral influence on pay awards and how easily such influence could filter through a supposedly 'free collective bargaining' system.

The early 1960's witnessed the start of overt incomes policies at the same time that the prospects for trade union growth and activism increased through grade dilution and resentment over low pay and shortages. Selwyn Lloyd's call for a 'pay pause' in 1961 coincided with cuts in public spending, and was enforced rigorously in the public sector whilst left to employers to apply in the private sector. It involved the blocking of nurses' wage claims, along with 34 other claims, and was seen as grossly unfair. It has been argued that it 'destroyed the paternalistic relationship between health workers and the central state' (Carpenter, 1988:308) - to the extent that such a relationship had ever existed. Nurses submitted a major claim in 1962

which was strongly resisted. The pay pause was followed by a less overt incomes policy in which the pay of public sector workers was again to act as an example to others. A period of campaigning and protests followed by COHSE and the RCN which attracted unofficial sympathy strikes and widespread public sympathy and began to affect the government's electoral prospects. COHSE had adopted a policy of high visibility outside the Whitley mechanisms so that some of the success would accrue to it. The award of the Industrial Court which followed was highly favourable to the nurses, and COHSE succeeded in recruiting thousands of general nurses. This period established a pattern of 'fall behind' and 'catch up' which was to be repeated many times.

An incomes policy was run by the Labour government from 1964-1970 at the same time that a number of developments paved the way for greater trade union membership and militancy. DOCAS (deduction of contributions at source) was introduced in 1966, and the General Whitley Council concluded an agreement on facilities for staff organisations at local level in 1968. The closure of mental hospitals initiated earlier by Enoch Powell, without corresponding provision in the community, and the increasing tendency to starve those that remained of resources in favour of the acute hi-tec sector began to feed through into particular problems with mental nurses. Problems continued with grade dilution and with the tendency to build larger district general hospitals with more impersonal and functional styles of management.

Initially, a voluntary prices and incomes policy was negotiated by the Labour government with the TUC and CBI in 1964, to be supervised by the NBPI. Although seen at first as a temporary measure, incomes policies in one form or another remained until 1970. In 1967, a compulsory freeze followed by a period of severe restraint was imposed by the government after its failure to secure cooperation with the trade unions (Carpenter,1988:342). The policy collapsed in 1969, with many public sector pay claims put forward. Nurses, along with many other NHS workers, had been particularly badly affected by the form of

the incomes policies under the Labour government which had been based on productivity arguments; private sector workers could make productivity deals with employers to get round the policies, which was not an option for nurses. The nurses' claim was submitted to the NBPI in 1967, and the 1968 Report advocated a wide range of pay and non-pay solutions to shortages it identified. However, the value of the pay award was very quickly eroded and unrest spread amongst nurses. The RCN initiated its 'Raise the Roof' publicity campaign of demonstrations and meetings in 1968, with the main pay aim being to obtain large pay increases for senior nurses to restore nursing's attractiveness to career-minded middle class women. As Carpenter has put it, the campaign 'was therefore an odd combination of pressure from below in the service of a salary demand biased considerably in favour of those at the top' (1988:355). COHSE joined in rather belatedly and increases were conceded by the government in awards for 1970 and 1971.

The Conservative government of 1970-1974 headed by Heath at first did not run an official incomes policy. However, yet again, public sector pay restraint was used in practice to act as an example to the private sector. The nurses' award again quickly fell behind, against cost of living and comparability measures, and a 'reevaluation' claim was submitted for 1972. This claim was for 26-40% and biased towards the lower end of the nursing scale. Negotiations were halted, however, by the 1972 statutory pay freeze introduced by the government. The NMC negotiators actually settled under Phase Three of the policy but resentment at effective cuts in real pay at a time of high inflation had built up and exploded with the election of a Labour government in early 1974. The RCN, NALGO and COHSE all campaigned for an independent review of nurses' pay with COHSE members taking limited industrial action and RCN threatening a mass resignation of nurses from the NHS. A review was duly promised by Barbara Castle.

This review took the form of an independent Committee of Inquiry into pay and conditions under Lord Halsbury (chair of the Doctors and Dentists Standing Review Body) and outside the Whitley Council system.

The Halsbury Report of September 1974 was to prove a high point in nursing pay for many years to come. The award amounted to some 30% overall. COHSE recruited many general nurses during the campaign and it appeared that militancy had been a key to the successful pay award.

The Labour government from 1974 to 1979 ran what may, with hindsight, appear to be a number of contradictory policies. Legislation on equal pay, sex and race discrimination, and health and safety was enacted, and the Employment Protection Act (EPA) and Trade Union and Labour Relations Act (TULRA) also gave further impetus to the spread of shop stewards and local bargaining. Recognition and an extension of bargaining rights at local level over a wide range of issues also took place in the public sector, with the possibility of appeal to ACAS beginning to put local management on the defensive. COHSE's outlook and composition changed and the RCN was forced in many ways to compete. As COHSE became increasingly occupied with 'professional' issues, the RCN, to gain access to the newly established bargaining rights, finally registered as a trade union in 1977 and began to develop local organisation, although it still remained unaffiliated to the TUC or Labour party.

However, against the background of improved employment legislation and trade union strength, wage restraint was again to be a policy feature and to cause problems. A crisis in public expenditure planning and control took place in 1974-5 and led to the introduction of explicit cash limits in 1976 (Thomson and Beaumont, 1978:122-6) and public sector expenditure cuts. From 1976 onwards, the loan agreement with the IMF led to a revision in the actual perception of the public sector, which was now seen as a 'drag' on the economy. The 1975 Social Contract agreement with the TUC at first favoured low paid workers with a flat rate £6 a week pay limit, but their position began to deteriorate in the second year of restraint. By the third year a 10% limit had been imposed without the agreement of the TUC, and cuts in the planned growth of the NHS led to non-replacement of staff when they left and cut backs in nurse training. The 1974 gains began to be eroded by inflation and, by 1978, big claims for pay increases and

reduction in hours were submitted. Callaghan finally offered 8.8% (against the limit of 5%) but, in January 1979, COHSE drew up guidelines for industrial action and took a full part in the 'Winter of Discontent'. The Labour government duly appointed the Clegg Comparability Commission to look at public sector pay and make recommendations, with 9% and a payment on account being made to NHS workers.

Labour lost the General Election, but the incoming Conservative government honoured the Commission's findings for nurses. In 1980, the Commission recommended an additional increase averaging 19.6%. The settlement was staged, with the initial increase held to the NHS cash limit of 14%, with the government setting aside funds for a shorter, 37½ hour working week (6% of the paybill) for 1980-81. This did not meet the nurses' demand to restore their salaries to their 1974 (Halsbury) level. The Conservatives had already announced that the Comparability Commission was to be abolished and that ability to pay rather than comparability should be the main criterion for public sector pay determination. Cash limits were also to be tightened and to become an implicit form of incomes policy in the 1980s.

By 1979 COHSE's total membership had grown to 215,000 (reaching 231,000 in 1982 before declining somewhat) and, with a hugely increased number of women and general nurses, it had become a serious rival to the RCN. COHSE and NUPE in 1980 together had over 200,000 nursing members (120,000 and 81,000 respectively) compared with 177,000 for the RCN. However, even after Lord McCarthy's review of the Whitley system (1976), the professional associations were still dominant on Staff Side and the collective voice of the TUC-unions was therefore still relatively unheard through official wage determination procedures. The scene was set for the 1982 dispute.

In the account conducted so far, the existence of relatively poor pay for nurses has largely been evidenced through the use of historical episode rather than quantified. There have, in fact, been relatively few attempts at 'objective' or 'rigorous' evaluation of historical

nursing pay levels and movements in the U.K., though rather more for the U.S.A. where pay is mainly locally determined. In part, this stems from the 'problem-led' nature of much interest in nursing pay and the concentration on groups or periods where especial difficulties are perceived (Gray, 1987:9). In part also, this stems from the intrinsic difficulty in evaluating such outcomes. The most detailed work has been conducted mainly under the auspices of official committees of inquiry such as the NBPI review of 1968, the Halsbury review in 1974 and the Clegg report of 1979-1980 or by dedicated health or nursing organisations (for example, Buchan, 1992).

Nonetheless, two of the very few studies on historical trends in nursing pay (Gray and Smail, 1982; Smail and Gray, 1982 - followed more recently by Gray, 1989) enable a broadbrush depiction of levels and trends, despite a number of unresolved analytical problems. Table 2.2 shows relative nursing pay outcomes between 1913 and 1981. It can be seen that although the establishment of the NHS did provide a once and for all uplift in nursing pay in comparison with lower

TABLE 2.2 FEMALE NURSES' GROSS PAY RELATIVE TO OTHER GROUPS 1913-1981

Female nurses' pay as a % of:	1913/14	1922/24	1935/36	1955/56	1960	1970	1978
Lower professional women	62	50	63	83	70	78	76
Lower professional men	35	33	43	59	50	51	56
All females average	110	103	128	113	102	116	112
National average	68	68	82	68	60	69	76

SOURCE: Adapted from Routh 1980 in Smail & Gray, 1982:5

professional men and women, and an improvement in hours and conditions which were to continue, nurses continued to fare badly against the national average and all lower professional comparators. Nurses' relative pay since the Second World War deteriorated in the 1950s and

1960s, improved in the early half of the 1970s, with a slight regression in the later part of the 1970s.

With respect to real pay, Table 2.3 shows that nurses' pay between 1949 and the late 1960s barely rose at all and fell through all broad grades for substantial periods between these dates. The early 1970s witnessed a sharp increase in real pay and the effects of the Halsbury awards can be seen here in contributing to a high point for trained nurses, as can the effects of awards in the narrowing of differentials in the second half of the 1970s between trained staff and student and unqualified nurses. The post-Halsbury decline in real pay of all nursing grades up to 1981 is also evident, and the Clegg awards of 1979-80 did little to halt this decline.

TABLE 2.3 PRICE INFLATION AND NURSES' PAY AT CONSTANT 1949 PRICES 1949-1981

YEAR (Sept)	RPI 1949=100	NURSES' PAY (£ per annum)		
		Trained	In-training	Unqualified
1949	100	475	210	275
1953	125.4	418.7	191.4	247.2
1958	148.7	418.3	184.9	247.5
1963	166.5	503.3	204.2	267.3
1968	202.4	481.7	210.0	261.9
1973	292.4	535.7	261.2	307.3
1974	343.2	630.5	343.8	373.0
1978	618.4	587.3	385.2	408.5
1979	720.3	552.5	355.3	370.0
1981	929.7	518.3	321.0	325.8

SOURCE: Adapted from Smail & Gray, 1982:22.

The findings on real pay are thus quite consistent with the findings on relative pay and pay levels, although of course it would be possible for nurses to fare badly relative to other occupations while maintaining significant rises in real pay. Thus, and despite the unprecedented economic growth in the UK economy since WW2, it appears that on only rare occasions have nurses benefitted greatly from it, the main occasions being in the early 1970s when they received the pay increases recommended in 1968 and 1974. Other major awards and

routine increments have not maintained their position in the national pay structure. Smail & Gray concluded that the establishment of the NHS and Whitley machinery had not significantly altered the pattern of fluctuating fortunes for nurses.

It should perhaps come as no surprise that the evidence on nurses' pay outcomes up to the 1980's, notwithstanding problems of methodology and objectivity, supports the more intuitive accounts in much of the literature in suggesting that nurses have fared poorly within the national wage hierarchy. Causation is, however, much more contentious. Smail & Gray, for example, concluded that, despite the long run narrowing of male-female pay differentials as elsewhere in the economy,:

an occupation such as nursing has distinctive characteristics which, irrespective of the institutional framework within which they work, will influence pay patterns and relativities. These characteristics may include high turnover, weak collective organisation and reluctance or inability to take industrial action, factors noted in this context by the Halsbury Committee of 1974...it is usually only when a special review committee is formed...that nurses and midwives witness a marked change in the level of their pay. The present negotiating machinery...has only been able to survive as a consequence of its occasional suspension. Problems of deciding upon an acceptable position in the national pay structure...are present in an acute form in this large occupational group and show every sign of worsening' (1982:7-8,25).

This chapter has, in contrast to some of these findings, emphasised the importance of the institutional framework and of power disproportionalities within and between the Sides, along the lines suggested by Clegg and Chester (1957) and nursing historians.

GRADING AND TRAINING

A final part of the history of nursing and nursing pay determination pertains to the interconnected role played by important changes in grading and training. As already noted, untrained or unqualified staff had always been used in the health system, so what was really at issue here was a change in emphasis; the new systems recognised that

such staff were engaged on 'nursing' duties. This point has been badly missed in much of the nursing literature. The line between 'nursing' work and domestic work has always been fluid. At different times and to a different extent, trained nurses, student nurses, assistant nurses/enrolled nurses, and nursing auxiliaries undertook 'domestic' activities. Ancillary staff numbers fluctuate partly in response to the extent that such activities are incorporated in the definition of nursing. The delineation and formalisation of 'grades' did not resolve this fluidity of tasks actually performed which is further underpinned by the level of public provision and the nursing care undertaken at home by untrained women.

A new grade of nurse was introduced in the War years. The 1943 Nurses Act gave assistant nurses statutory recognition through absorption of existing staff, with examination and subsequent admission to a 'Roll' of the General Nursing Council of new staff after two years' training (the first tests were conducted in 1949). The recommendations of the 1905 Committee were thus finally enacted. These nurses were not to have access to higher posts, however.

As with the 1919 Act, a wide variety of interests were involved. The creation of a Civil Nursing Reserve, in an attempt to resolve shortages, had produced a de facto three-tiered nursing hierarchy: trained nurses, assistant nurses and nursing auxiliaries. The Rushcliffe Committee established a scale for them and 'it became obvious that the ministry was committed to a long-term role for such personnel' (Dingwall,1988:115). The TUC- unions' support for the Bill was no doubt motivated by their desire to obtain proper recognition and pay for assistants. The RCN had initially followed its long history of resistance to this change, because it was perceived as lowering standards and providing the possibility of nursing substitution. However, de facto substitution had already taken place, and the RCN was finally moved to accept enrolment to gain 'control' of this grade. The fear that such unregistered 'nurses' might be recognised as a valid nursing alternative and thus undermine the main reason for a lengthy training and professional qualification may also

have been a powerful incentive. Employers had effectively been providing the training they felt was needed for assistants and, sometimes, auxiliaries, and the nursing hierarchy was becoming blurred, with assistant nurses hired through cooperatives or agencies frequently gaining higher salaries than registered nurses. Employers initially resisted the formalisation of assistant nurses, which would require training controls and possibly increased pay but then began to see advantages. Employers' actions and Ministry of Health pressure eventually decided the issue. The RCN set up the Horder Committee in 1941, which recommended that:

The Assistant Nurse of the future should become one of the most stable elements in our national nursing service - an integral part of the profession, and a person whose status offers the key to the improved training and employment of her senior partner, the State Registered Nurse. Moreover it is only when the services of the Assistant Nurse have been defined and regulated that matters affecting the State Registered Nurse can be brought into line - her student status assured when in training and her skill used to the best advantage when she is trained (Horder Report in Abel-Smith, 1960:170-171).

As can be seen, the above was largely post-hoc rationalisation. The 1943 Bill was, as had been the 1919 debate, dominated by questions of experience versus training for admission to the Roll and by questions concerning the standards which should be set. In 1947, the Wood Committee recommended a shorter training, as had COHSE, and from 1950 the GNC introduced a system whereby there was to be one year's training followed by one year's supervision for qualification (Abel-Smith, 1960:231). Untrained staff were again pushed to the periphery of attention.

The vast majority of those originally assimilated to the Roll did so through the 'experience' mechanism. However, as they retired, new 'trainees' failed to keep pace. The limited pay and prospects of enrolled nursing were not particularly attractive to prospective recruits against the training requirement. Two state policies, however, led to the dramatic expansion of this grade. Firstly, from 1948 the recruitment of trainees from ex-colonial or British Commonwealth countries began and was pursued vigorously from the early

1950's. These immigrants were disproportionately channelled into EN training, and for unpopular specialities, and were less likely to be employed and have their visas renewed after training. This trend peaked in the early 1970's and has been declining since (see Salvage,1985:37-41). Recruitment from Eire, begun earlier, was also continued. This undoubtedly caused divisions amongst staff and COHSE, for example, did not actively seek to recruit overseas health workers until the 1960's. Secondly, in its 'Codes of Working Conditions' in the mid-1940's, the government encouraged the recruitment of married women and part-timers, amongst other measures designed to improve the attractiveness of hospital work and resolve shortages (Carpenter,1988:254). This had also been recommended in the Wood Committee Report (1946) and 4th Horder Report (1949) (Abel-Smith,1960:188-9). Such women had been largely excluded from nursing by the high requirements for registration and of full-time nursing itself. Through these measures, enrolled nurses grew to account for a third of qualified nurses by the end of the 1970's.

Faster grade dilution was achieved in the 1950's, before the expansion of EN grades, through the increase in numbers of unqualified staff. As Abel-Smith put it 'after the sudden departure of nursing auxiliaries at the end of the war, hospitals found they could not manage without them and started recruiting unqualified women again' (1960:234). These women were largely employed on domestic tasks in the acute sector, but also for nursing duties in the chronic sector, which experienced the worst shortages of qualified nurses. Such untrained nurses were thus employed to fill gaps left by the shortage of trained staff, or as a cheaper alternative, rather than to create a balanced nursing team. The recognition in 1955 of the Nursing Auxiliary (NA) role owed much to the fact that these staff were previously paid on ancillary rates which offered higher overtime and weekend rates, reflecting the conditions of male orderlies. It was thus cheaper to redefine this grade and set a payscale for it - the Ministry was indeed keen to do so. By 1958, there were more untrained staff working in the hospitals than there had been before the war (Dingwall,1988:116). The increase in numbers of NAs was achieved

alongside a decrease in the number of nursing students. The NA grade was again disproportionately occupied by women working part-time or ethnic minorities. From 15% of total numbers of nurses in England and Wales in 1949, part-timers grew to account for nearly 40% in 1977 (calculated from Gray and Smail,1982;6). NAs were concentrated in unpopular specialities, especially those for the chronic sick. This grade dilution was in large part set in motion by state policy, both through circulars (e.g. the 'dilution' Circular RHB (53) in mental nursing - see Carpenter,1988:286) and through employer behaviour under conditions of resource squeeze.

Patterns of stratification in the nursing hierarchy, existing prior to WW2, were thus built upon and reinforced with formal grades and qualification barriers. A marginal increase in the proportion of qualified nurses by the early 1980's, despite a decrease in the proportion of registered nurses, was achieved through the continuing growth of the EN role, as a relatively cheap form of qualified nurse with very little chance of advancement up the pay ladder. Likewise, training as a whole decreased substantially and cheap student labour was substituted for by NAs, who again offered cost advantages through lower pay and limited promotion opportunities. Grade dilution has thus been an important part of cost-minimisation strategy, alongside the operation of pay determination mechanisms [3].

There are a number of possible reasons why this situation could not be considered a 'steady state' and to have expected some shifts in the trends for the 1980's. Firstly, this process has been characterised here as 'grade' rather than 'skill' dilution. The discussion of initial absorption onto the Register and Roll has shown that experience rather than training played a strong role. The length and

[3] Its significance was noted in passing in a further paper by Gray & Smail (1982) on reasons for the increase in the Scottish nursing paybill between 1948 and 1979, which showed that changes in nursing composition, especially those arising from grade dilution, were an important downward influence on pay.

content of 'necessary' training has also been a point of issue both within and amongst nurses and employers. Secondly, grade dilution could be seen as a cheap alternative to adequate funding of the health service and allowance for competitive pay rates and training expenditure. However, grade dilution in turn lowers the attractiveness of all grades, as none is adequately compensated through this solution. Low pay is institutionalised and may lower morale, particularly as low pay becomes associated with poor conditions in unpopular specialities. Shortages may therefore not be resolved.

Shortages did indeed continue in the post-war era and periodically emerged as points of major concern. If, as has been suggested above, related resentment on the part of nurses was not handled within the Whitley machinery, it could be expected that it would surface outside this mechanism in the form of militancy. Finally, grade dilution laid the conditions for the growth of trade unionism. This was particularly true for NAs who were excluded from RCN membership. In theory, incorporation of ENs could have worked either way, and initially should have worked to the advantage of the RCN. However, the lower pay and status of this group, the attitude of the RCN itself, and trade union efforts to attract ENs along with registered nurses made their allegiance a contestable area. Some of these effects have been noted in the earlier examination of pay determination.

CONCLUSIONS

This chapter has provided an historical context against which changes in nurses' pay, grading and training will be evaluated for the 1980's. It was argued that although patriarchal influences long preceded those of capitalism, the two influences combined to produce a healthcare system and division of labour within it which reflected and supported the wider productive system and deeply-rooted inequalities in gender, class and race. However, despite some semblance of structural continuity, the 'system' could also be viewed as prone to intermittent crisis. Capital's interest in health services is more clearly viewed

as a measure of costs and benefits, which may be neither rationally calculated nor historically constant. Delivery systems and use of labour may equally be irrational or inefficient. A major force in influencing this cost-benefit estimation has been labour, and its trade union organisation and political activities.

The prior stratification of the labour force could be seen to have had a constraining impact on the effectiveness of nursing representation through the competition between 'professional' and 'trade union' aims. However, although the 'professional' associations were shaped and supported by the institutions of the wider productive system, the 'balance' between the power of professional associations and of trade unions could be viewed as a delicate one for government and employers. Professionalisation can only proceed to the extent where it does not threaten the existing hierarchy or add substantially to labour costs. Trade unions on the other hand have both the desire and the potential to affect both pay and conditions of work and the funding arrangements necessary to accommodate them.

The account provided here suggests that the establishment of the NHS and a new pay determination system did not mark as significant a break with the past as many believed. Though these represented some gains for labour, both were again tilted in favour of maintenance of the status quo. The importance of understanding the particular role and functioning of institutional mechanisms and of power imbalances could be seen in the evaluation of pay determination. Governments have conflicting objectives, however, and the importance of distinguishing between political administrations could also be seen, despite some appearance of continuity in treatment of nurses. Thus, ambiguous policies might be run in tandem. For example, despite the operation of incomes policies and cash limits, changes in trade union legislation and organisation were seen to have an important impact on nursing trade unionism and such developments led to changes in the professional associations.

The chapter also has suggested that the cost-benefit calculation in cost-minimisation strategy may be difficult, given uncertain feedbacks. It has been argued that an important, and little noted, influence was the grade dilution that took place in the post-WW2 decades, both as part of a strategic desire to reduce labour costs and with the expansion of 'cinderella' services. Grade dilution had a number of effects, including loss of morale and the strengthening of conditions for the growth of trade unionism. The irritant effect of incomes policies and of continuing low pay also caused feedbacks in the form of attempts by trade unions to improve nurses' terms and conditions or the more direct loss of nurses and shortages.

In these respects, an emphasis on continuities in nurses' position within the wage hierarchy may mask some of the changes taking place and their causes. The chapters which follow address the controversy over causation in nursing pay determination and pay movements through a detailed study of the 1980's. An evaluation of the new pay review system and of changes in grading, grade-mix and training, against the wider background of healthcare provision and policy decisions, permits an illustration and expansion of some of these historical themes.

CHAPTER THREE

THE ORIGINS OF THE NURSES' & MIDWIVES' PAY REVIEW BODY

The previous chapter provided a historical evaluation of nursing and nursing pay determination. This chapter presents a more detailed analysis of the structures, processes and outcomes of arbitration and pay review in nursing pay determination prior to the 1980's, and of the immediate context in which the PRB was formed. It reviews consultations for the PRB, the arguments put forward for its operation, and its original remit. Finally, the analysis extends to the operation of other Review Bodies and some preliminary conclusions are drawn on the nature of pay review.

THE ANTECEDENTS OF THE REVIEW BODY

As Chapter Two noted, it has been argued that the Whitley system of pay determination for nurses and midwives survived largely because of its periodic augmentation or suspension (Smail & Gray, 1982). The forms of arbitration brought in to play when the Whitley Council failed to reach agreement on pay increases differed, but have been a vital part of wage determination for nurses in the post-World War Two era, as for other public sector workers (see Winchester, 1983:163). Arbitration was viewed by the Webbs as a system of decision-making on terms and conditions of employment through the 'fiat of an umpire or arbitrator'. This system was seen as supplementing rather than supplanting collective bargaining and as a temporary expedient to resolve wage disputes (1897:243). In nursing pay determination both these features have in practice been stretched to their theoretical limits, but the systems employed can still usefully be defined (albeit broadly) as forms of arbitration.

The forms that arbitration took in the realm of nursing pay determination changed over the post-WW2 decades. Paradoxically, this may point to a more limited role for arbitration as a tool in conflict resolution than is sometimes assumed. The delays caused by arbitration

to nursing pay settlements could be viewed as a source of irritation to nurses themselves, while proving instrumental to the government's desire to control expenditures. Moreover, arbitration enabled government to set conflict at one step remove without tackling underlying problems in nursing pay determination and outcomes. It would thus be possible to view the changing systems as having more to do with an on-going response to the growth in nursing trade union membership and militancy over pay, arising from the failure of nurses' pay to rise in the national wage hierarchy, than with a more general policy stance towards arbitration itself.

These points may be seen in the frequency and persistence of the use of arbitration in nursing pay determination in the NHS. In the immediate post-WW2 years, arbitration was a feature of nursing pay determination. Subsequently, between December 1952 and 1956, no fewer than eight awards relating to nurses' pay were made through arbitration by the Industrial Court (Gray, 1989). With the blocking of traditional NHS staff side applications for arbitration in the 1959 Terms and Conditions of Employment Act, arbitration then resurfaced in different guise. In the 1960's, this tended to be in the form of ad hoc reviews and inquiries and there were four such 'special reviews' in the 1960s for nurses (Halsbury, 1974).

The late 1960's and 1970's saw a further change in emphasis in the form of arbitration, with a number of non-Whitley, 'independent' reviews into nurses' pay. The first of these was the National Board of Price and Incomes (NBPI) review of 1967-8, which was followed in 1970 by another Whitley 'internal' review which recommended 'catch up' pay increases. In 1974, the second independent inquiry was conducted under the chairmanship of the Earl of Halsbury. The third independent inquiry was the Standing Commission on Pay Comparability in 1979-1980, with Professor Hugh Clegg in the Chair.

The NBPI was constituted to examine and co-ordinate a wide range of incomes as part of a broader economic policy. The 1967/8 review took place in the context of a series of mainly productivity-based incomes

policies and growing trade union membership and militancy. The nurses' claim was thus submitted to the NBPI at a time of severe pay restraint and the NBPI's recommendations emphasised non-pay solutions such as efficiency improvements through better deployment of staff and revised staff patterns. The pay recommendations increased differentials and were targeted at combatting shortages of specific grades, such as staff nurses. Outcomes were conservative and a further review was necessary only two years later. The Halsbury Report later argued that the recommendations had been 'limited' because 'the independence of the Board was itself circumscribed by the need to observe the pay restraint measures then current' (1974:12).

A period of unprecedented pay militancy erupted amongst nurses following the NBPI award. Nurses' pay fell behind against cost of living and comparability measures at a time when women were becoming increasingly vocal in their claims for equal pay with men. Demonstrations and publicity campaigns took place, fuelled by the successive overt incomes policies and de facto public sector pay restraints. The RCN, COHSE and NALGO all campaigned for an independent review of nurses' pay. With the election of a Labour government in 1974, the Committee of Inquiry chaired by Halsbury was finally set up, dedicated to a review of nursing pay per se rather than the concerns of wider economic policy. The resulting remit was one of the broadest ever granted to a review exercise before or since, 'to examine the pay structure and the levels of remuneration and related conditions of service of nurses and midwives', a remit later extended to cover the professions supplementary to medicine (Halsbury Report, 1974:1).

In its structure and process, Halsbury bore many of the hallmarks of new pay review bodies constituted in 1971 for key parts of the public sector, and much of its style was to be carried forward into the new Nurses' and Midwives' Pay Review Body. The Halsbury Committee was appointed by government, and its members were not intended to be directly representative of any particular interest group, or to have any special expertise in nursing or health. The Committee consisted of seven members, for the main part male, and drawn from an elevated

social background. In this context it is interesting to speculate on the degree to which the sociology of pay review includes in its 'judicial' elements a degree of pomp and ceremony, in membership and process, which reflects the deeper structures of hierarchy and deference embedded in wider society. Given the hierarchical nature of nursing and its historical roots in obedience and service it would be interesting to speculate further on the importance this has for the acceptance of pay determination through such a system.

From the vantage point of pay review in the early 1990s it is notable that the detailed arguments presented by the *Halsbury Committee*, in its ninety-page report, possessed a remarkably conciliatory and sympathetic tone, and adopted an ostensibly radical approach. The report foreshadowed later developments by disassociating its recommendations from the effects of previous industrial action: 'We want to make it clear that the pressure which the industrial action was designed to create has not influenced our recommendations in any way' (1974:4). However, it went on to promise the first true evaluation of the place of nursing in the national pay hierarchy. Members of the Committee who had visited hospitals proved sympathetic to the plight of nurses, noting the extent to which nurses worked unpaid overtime, undertook non-nursing duties, had inadequate numbers of supporting staff, and took second jobs and 'moonlighted' because of shortage of money.

'Evidence' was provided by Staff Side and Management Side. The Staff Side claim was for an average 25% increase, and an increase in differentials. They supported this claim with evidence on absolute and relative low pay, external comparability, the gendered nature of the profession, and increased workload and responsibility. Management Side provided a muted and sympathetic evidence, which reflects the particular nature of the Halsbury exercise. They had attempted to find common grades or men's rates but 'it was difficult to find close analogues except between the nursing auxiliary and the ward orderly'. They noted the grade dilution of previous years and also that 'the total number of nurses was well below optimum standards' and said

there was a need to maintain quality. They pointed to specific shortages and recruitment and retention problems, and they 'welcomed' the present review. Again in the light of future events, Management Side were remarkably unforthcoming about the criteria which should be employed to determine pay, apparently leaving this to the discretion of the Committee (ibid:18-22).

The Committee outlined the results of its own enquiries and surveys, and noted substantial recruitment and retention problems, with shortages of some 17% against establishment (a striking figure based on a study by COHSE). The Committee also conducted its own earnings comparison using a base year of 1970, despite an acknowledgement that in this year nurses' settlements 'were low'. Female nurses were compared with female non-manual workers, male nurses with non-manual male workers, and nursing as a whole compared with other external occupations such as teaching and the civil service. Direct comparisons were also made between nursing pay increases and the rate of change of prices as measured through the RPI, and earnings as measured through the AEI. The conclusion was reached that the earnings opportunities in nursing had become 'relatively unattractive' (ibid:23-32), and the final recommendations added some 30% to the overall paybill, while simplifying the grading structure and widening differentials between the main grades of nursing staff.

There are several important factors to note in the way the Committee reached and reported its conclusions (ibid:33-54). Firstly, the main basis of the report appeared to be general comparability and, in recommending some form of job evaluation for the longer term, the Committee stressed the role of perceived fairness in calculating nurses' pay through comparability exercises. They felt, however, that job evaluation could not provide all the answers as: 'in the end, the pay levels appropriate to a particular section depend on subjective judgements of acceptability to the community as a whole'. In this important respect, it should come as no surprise that there was no clear linkage between the Committee's analytical system and percentage pay outcomes, although recruitment and retention and differentials

were also important factors. As Seifert has put it: 'the arguments are...to placate everyone and to allow each relevant group to find some comfort - the hallmark of the arbitrator' (1992:281).

Secondly, for the Committee the importance of recruitment and retention issues, especially shortages, was that they reflected problems with pay. The solutions were therefore clearly seen to revolve around improvements in pay as these were acknowledged to provide important signals in the labour market. The general increase across the board was intended to improve staff numbers at all levels, and the vital linkage with comparability is evident. However, believing that 'the relative decline in nurses' earnings over recent years has contributed to the change of balance in the numbers of qualified and unqualified staff', the Report recommended the widening of differentials, to boost the proportion of qualified staff.

Thirdly, despite paying considerable lip service to the view that nursing should not be undervalued because 'it is predominantly a woman's profession', the report nonetheless used female-female comparisons throughout, a point which suggests that rhetoric should be distinguished from practice in evaluating measures of comparability. It also suggests a change in form rather than content in responding to the external pressure of the Women's Liberation Movement and wider legal reform.

In terms of pay outcomes, the Halsbury award was to remain a high point. In the following years, nursing pay again fell behind and differentials also narrowed, with auxiliaries and student nurses again improving their position vis-a-vis qualified nurses (see Smail and Gray, 1982:10). The latter point undoubtedly reflected the growing strength of nursing trade unions. Pressures again built up from the nursing unions and associations, spurred by incomes policies and cuts in the planned growth of the NHS with the associated non-replacement of staff and cutbacks in nurse training. By 1978, large claims for pay increases were submitted and nurses took part in the 'winter of discontent' in early 1979. This militancy culminated in the

appointment of the Standing Commission on Pay Comparability by the Labour Prime Minister in March 1979 to examine the terms and conditions of employment of some 19 different groups of workers. It was to report in each case on the 'possibility of establishing acceptable bases of comparison with terms and conditions for other comparable work and of maintaining appropriate internal relativities' (1980:iii). Report Number Three on Nurses and Midwives appeared in January 1980.

As far as nurses were concerned, the perceived need for some longer-term method of pay determination had long been growing in importance on the political agenda, augmented by the ever-more vocal criticisms of the Whitley system itself (for a detailed review, see Seifert,1992:214-220), expressed formally through the report published in 1976 by Lord McCarthy, 'Making Whitley Work'. The aspirations for the Commission therefore extended to finding a more 'rational' and 'long-term' basis for determining the levels of nursing pay. This, however, proved to be an extremely difficult exercise, as can be seen in the Commission's process and evidence of problems with what might be termed 'refined comparability' (Kessler,1983:85).

The Commission initially argued that job-for-job comparisons were better than any form of indexation but saw little potential for actually conducting these given the lack of similar jobs. A form of factor analysis, or job evaluation, was therefore undertaken, as had been suggested in the longer-term recommendations of Halsbury. The exercise was conducted by commissioned external consultants, and factors were based mainly on know-how, problem-solving and accountability. Otherwise the review process proceeded much as Halsbury, with evidence, visits, surveys and comparisons. Staff Side said that their pay was low compared with similar occupations and wanted salaries to be set so that their average earnings would not be less than those of average male non-manual employees. In their choice of comparators, Staff Side were clearly attempting, yet again, to establish a linkage with male comparators. They criticised the methodology of the comparability study which they saw as undervaluing

the nursing profession, and asked the Commission to take other evidence into account. Some of the concerns with the methodology focused on the fact that only 134 jobs were studied for half a million workers in 60 distinct jobs and that the consultants' data bank covered only those organisations that used their services. Staff Side, for example, queried if those organisations were 'good employers'. Management were again muted in their evidence, claiming that they wanted nurses to be 'justly remunerated' and to have some machinery which enabled their pay to be kept 'up to date' (1980:7-11).

The study produced scores in terms of job units. As an example, a Regional Nursing Officer scored 1418 (median) and a nursing auxiliary only 98. Under this scheme, students were rated more highly than auxiliaries. The Commission reported that it thought that 'the job of the nursing auxiliary, who is unqualified, is much more closely akin to the jobs of ancillary staff than to the job of the qualified nurse' (ibid:16). Thus, in practice, the scores were broadly consistent with the existing hierarchy and a desire to broaden differentials and maintain a link between ancillary workers and auxiliaries. The scores were then used to produce recommended increases required to bring nurses' pay in line with consultant market median base pay, adjusted for various differences in terms and conditions.

The final recommendations, however, differed somewhat from the consultants' recommended percentages for the main grades and substantially for the minority grades. As the Commission put it, 'job evaluation cannot be an infallible guide...It is a method of rationalising judgements about relative pay and reconciling differences between them' (ibid:19). Thus, in the end, despite the attempt to provide some systematic basis for pay awards, the review process had to provide a measure of judgement and the final percentage awards remained unexplained. The Commission itself noted the 'experimental' nature of the exercise and the need to produce recommendations quickly for the year in question. In all, an increase of some 19.3% of the paybill was recommended, payable in two equal parts. However, as can be seen in Table 2.3 above, this did not

restore nurses' pay against cost of living increases, and nurses did not regain the position achieved against comparators with the dedicated review undertaken by Halsbury.

In 1979, the Conservative government came to power. The Clegg recommendations were honoured but the Standing Commission was soon abandoned and the gains eroded. Nonetheless, the seeds of a pay review system which would be not only 'independent' but also of a less 'temporary' nature can be seen in this account. Many of the main features of pay review, along with some of those from the prior operation of Pay Review Bodies for other groups of workers, were carried forward in the new review process. However, the differences were to prove important.

In the Autumn of 1981 health service workers decided to combine forces in a campaign to gain increases in pay which for two years had been below the rate of inflation. The campaign was facilitated by the new common settlement date for all major NHS pay groups of 1 April 1982 and coordinated by the TUC Health Services Committee (HSC), with a 'common core' claim of 12%. The Government responded with an offer of only 6%. An appeal by the TUC HSC to the Secretary of State for Health and Social Services received a negative response, and subsequent industrial unrest lasted through most of 1982. The scale of this unrest remains notable - on one account, thousands of health workers took industrial action, reducing 1,500 hospitals to an emergencies-only service whilst public support magnified along with the support of trade unionists. A national day of action took place on 22 September 1982, with sympathy action by many workers and 'one of the largest trade union demonstrations ever seen' in London (Carpenter,1988:378). On another account, this was the 'most sustained and severe disruption ever seen in the service (nearly a million days were lost)' (Salvage,1985:140). The campaign revealed the political vulnerability of a government which, at this time, was at a peak of unpopularity. On 18 January 1983, Mr Ray Powell in Oral Answers in Parliament asked Mr Norman Fowler, with reference to the wider industrial action, 'Is the Secretary of State aware that 3

million working days were lost, compared with the 600,000 that were lost during the winter of discontent, directly as a result of his inability to settle the dispute sooner?' (Hansard).

The Pay Review Body emerged as a potential solution in the middle of this long and costly dispute, during which the RCN twice turned down government offers and some general nurses, including RCN members, had for the first time protested, picketed, worked to rule and even withdrawn their labour. Talks had been taking place between the Government, management and Staff Side since 1980 on possible arrangements to prevent nurses' pay falling behind other groups, with little success. However, in the end:

the promise proved to be the government's trump card. Fed up with disruptions to the service, anxious for more money in their pockets and hopeful that a new arrangement could be reached, nurses finally settled for a 12.3% rise spread over two years, and the promise of a new pay review body (Salvage,1985:142).

The offer of a review body has been viewed as an attempt by the Government 'to divide the unity of health staffs' on one of the notable occasions when higher pay offers to certain groups had previously been rejected in favour of a common claim (Carpenter, 1988:379), and the dispute indeed 'limped to an end' after RCN members accepted this third offer (Salvage,1985:141).

The importance of the RCN's no-strike policy and the traditional reluctance of most nurses to take industrial action has been stressed in some accounts as part of the rationale for separating this group from the other NHS workers (ibid), and this was enshrined in the terms under which the PRB was established. Norman Fowler stated that 'the review body recognises the special position of nurses, who do not take industrial action' (Hansard, January,1983). There was, however, a certain irony in this position after a bitter dispute in which some nurses had taken industrial action for the first time. If this represented a learning curve, then Government clearly did not wish the learning to continue, as far as this vital group of workers was concerned.

REMIT AND CONSULTATION

Early in 1983, following the statement of 9 November 1982 in the House of Commons announcing the proposed establishment of a Pay Review Body (PRB) for nurses and midwives, the government issued a Consultation Document. If the PRB was seen as a means of conflict resolution, the document and the initial responses to it swiftly revealed a number of doubts and concerns about the new review body, and the manner of its operation. Although some of these were undoubtedly expressed as part of the political manoeuvring that tends to surround changes in industrial relations, some were rooted in deeper concerns which continue to be of significance.

In the Consultation Document, the government proposed that the new review body should follow the same general pattern as the Doctors' and Dentists Review Body (DDRB). In this respect, the Royal Commission (Pilkington) which reported in 1960 had identified three broad objectives: to avoid disputes over remuneration; to provide an assurance to staff that their pay would be determined on a fair basis; and to provide fair treatment for the taxpayer. The new review body for nurses and midwives was to be an 'independent body' and to report to the Prime Minister, with a secretariat provided by the Office of Manpower Economics (OME). It would be 'free' to determine its own method of working, obtain any information required and take evidence from interested parties, and was to deal only with remuneration, leaving other terms and conditions of service to be negotiated elsewhere. The 'important links between pay and terms of service' were early recognised and it was suggested that the PRB would need to be kept informed of changes so that it could 'express a view to the negotiators about the changes proposed in respect of their implications for pay' (DHSS:1983). With regard to coverage, the consultation document proposed the inclusion of all qualified and unqualified staff currently in the Nursing & Midwifery and Professional and Technical 'A' Whitley councils. Perhaps most importantly, the consultation document set the initial agenda for the process which would follow and sent a strong signal that the

comparability ethos in Pilkington had been dropped:

the Government will look to the review body to give due weight to economic and financial considerations, as well as to the recruitment, retention and motivation of the staff concerned (DHSS,1983).

The TUC unions initially took a sceptical position about the replacement of a 'free collective bargaining' system with that of the PRB. The reasons they did so, however, remain highly pertinent for the current discussion of arbitration and review. COHSE's response to the consultation document noted that:

A new system of pay determination will not of itself avoid disputes in the NHS. It is when the Government interferes in collective bargaining procedures that disputes occur...the disputes that have taken place have been far less about the particular system adopted and far more about the actual level of remuneration offered...the existence of the Doctors & Dentists Review Body (DDRB), referred to several times in positive terms in the consultation document, has not avoided disputes arising over doctors' and dentists' pay (March,1983:1)

It was further pointed out that they did not see the PRB 'as in any way limiting staffs' right to take industrial action', and that it was hoped that the Review Body would establish and maintain fair levels of pay for nurses and midwives 'so that the taking of industrial action becomes unnecessary' (ibid). The advisory role of the PRB was also criticised from the outset and anticipated as problematic: 'the proposal that the Review Body report directly to the Prime Minister who will then decide to what extent the Report is implemented stands not only in contradiction to the commitment to the independence of the Review Body but in potential conflict with ensuring fair pay for nurses...' (COHSE,1983:2).

Trade union officers in interviews amplified their view that 'free collective bargaining' through the Whitley system had always been a chimera. They felt that, in practice, government had disproportionate influence on the 'management' side and it was in the last resort always up to the government to decide on pay awards. Nonetheless, the TUC-unions were wary of seeing the principle of negotiation abandoned, and argued for its retention in some form. For example, concerning

the proposed terms of reference, COHSE noted its preference for an arrangement whereby the respective Whitley councils would be presented with the Review Body's respective reports for discussion, debate and negotiation, with the results then continuing to be referred to the Secretary of State. The trade unions were, in fact, unanimous in favour of retaining the Whitley negotiation machinery (Financial Times, 8.4.83, GMB Journal, Aug/Sept, 1983). It is interesting to note that the actual structure and membership of the PRB drew little comment and this reflects the extent to which the unions had become accustomed to this form of arbitration and review.

The crucial question of the occupational coverage of the PRB was a controversial point and Dyson (1983) noted that 'there are strong voices within the Royal College of Nursing who will disapprove of the proposed inclusion of auxiliaries and assistants'. COHSE and the other TUC unions who also anticipated problems were very anxious to ensure that unqualified staff were included:

For nursing assistants and auxiliaries to be excluded would be a severe blow to staff morale [and] would cut right across the reality and continuing need for a strong and unified nursing team in the hospitals. Nursing assistants and auxiliaries work is nursing work; their duties, nursing duties. Given the very close inter-relation and interdependence of qualified and unqualified nurses in the therapeutic team, such a step would only succeed in dividing staff against each other through arousing a sense of bitterness and fermenting of grievances.. There is considerable evidence showing that without unqualified staff the vast majority of psychiatric, geriatric, and mental handicap hospitals simply would not function... (COHSE, 1983:3-4).

The issue of coverage indeed resurfaced in July 1983, following a statement on the review body by the Prime Minister in the House of Commons. Margaret Thatcher announced that the review body would 'deal separately' with unqualified and qualified staff following 'concern' expressed by the nursing and allied professions about being combined in a single review body, and also that the government would 'reserve the right to exclude...any groups that do resort to industrial action' (see Hansard V.46, 28.7.1983 - Written Answer). The RCN had wanted to restrict the operation of the review body to qualified staff and feared that it might be difficult to hold unqualified staff to a no-

strike commitment. The Glasgow Herald noted that the RCN already had a no-strike commitment and regarded the review body as a sort of quid pro quo (30.6.1983). The RCN informed Mrs Thatcher that it wanted:

to see the NHS moving towards the provision of a wholly qualified nursing service. To include nursing auxiliaries within the PRB would give them a credibility as nurses that would not serve this objective (ibid).

The Prime Minister's statement was greeted with outrage and some very colourful language by the TUC unions. David Williams (then General Secretary of COHSE) said that 'it means that without any debate in Parliament and without any discussion with the Trade Unions involved, the Government is to deny the right to take industrial action to more than half a million people'. He added that '...the Government's plans to deal separately with qualified and unqualified nursing staffs could easily cause bitter and unacceptable divisions between the two groups' (COHSE News Release, 28.7.1983). John Edmonds (then National Industrial Officer for Public Services, GMB) also 'slammed Tory proposals for a no-strike clause as the price for the new N&M review body' calling the proposal 'the nastiest little political trick imaginable'. The GMB saw this as an 'unequal bargain', with health service staff having to give up their right to strike, whilst the Government remained uncommitted to accepting the decisions of the proposed review body (GMB Journal, Aug/Sept, 1983).

In the event, the Prime Minister informed the RCN on 29th June 1983 that the Government would not go back on its pledge to include all staff currently within the purview of the NMC in the new review body. The paragraphs on industrial action, and the intention to deal separately with qualified/unqualified staff and abolish the N&M Whitley Council remained and can be seen in the First Pay Review Body's Terms of Reference (1984:Appendix A:18)

With respect to the criteria to be used by the PRB in forming its recommendations, these were similarly subject to much debate as might have been expected from the prior process of arbitration and review. The Government's explicit attempt to skew the criteria towards

'ability to pay', however, was unsubtle compared with these prior processes. COHSE expressed its 'strong exception to the letter and spirit' of the proposals, which it felt indicated 'simply an alternative expression of primacy being given to market factors and affordability':

[This] bluntly amounts to saying that we cannot expect the strong case of the concerned groups to be considered and judged on its merits. Instead, the fate of the case will be determined on how it fits in or does not fit in to the vagaries of Government economic policies. Experience has shown how these can shift, creating rather than overcoming instability in pay determination...We note the considerable extent to which both market factors and affordability are Government influenced and determined, and cannot therefore be seen as neutral criteria in pay determination. (1983:6).

This concern was echoed by NUPE, who argued that there was no clear correlation between market forces, the ability to recruit and retain, and pay levels. It was felt that the impact of the market would be reflected in job comparisons, and that, in any case, the monopoly position of the NHS in relation to nurses would make such market forces factors 'meaningless'. NUPE further suggested that the PRB should consider job comparisons based on nurses' actual work rather than their job descriptions, that it should not pay undue regard to internal NHS relativities, and that a special value should be determined for nurses' responsibility for human lives and health [1] (Financial Times, 8.4.1983. Further problems were raised with the reference to motivation and the absence of reference to low pay. COHSE pointed out that 'motivation' was open to the interpretation that the only thing driving health staffs was financial reward, and was 'deeply offensive to the caring role of the staff and their considerable contribution to the community' and saw the absence of reference to tackle absolute and relative low pay among nurses as 'both a disturbing omission and a critical weakness' (1983:6). NUPE suggested that the Review Body should set minimum rates of pay to deal with the problems of low pay in the NHS (Financial Times, ibid).

[1] See also 'X' factor in the AFPRB, below.

The offending paragraph on criteria did not appear in the Terms of Reference and was replaced by: 'The Government will, as proposed in the consultative document, submit evidence on economic and financial considerations, and on such factors as recruitment, retention and motivation of the staff concerned' (Hansard V.46, 1983: PRB1, 1984, Appendix A:18). Whether this was a moral or material victory is reviewed in the next two chapters, but this opening volley between government and trade unions shows that a number of important points of potential conflict were apparent from the start. There can be little doubt that a number of the above concerns were expressed 'colourfully' by the TUC-trade unions, partly through political expedient, partly as a bargaining stance, and partly through the need to maintain 'image' as far as membership was concerned. However, many of the points raised were, and continue to be, of abiding importance in the determination of nursing pay.

THE REVIEW BODY SYSTEM

The precedents for the specific form for the Nurses and Midwives PRB, alongside the particular history of arbitration and review in nursing pay determination, were the Pay Review Bodies set up under the Edward Heath government. These were the Review Body on Armed Forces Pay (AFPRB), the Review Body on Top Salaries (TSRB) and the reconstituted Review Body on Doctors' and Dentists' Remuneration (DDRB). The structure and processes of these PRBs were very similar to that of Halsbury. In addition these PRBs were given common terms of reference and an interlocking membership, argued to reflect key overlaps in the characteristics of the occupations covered by the Bodies, such as skills and levels of responsibility. 'It was also perhaps assumed that none of the groups concerned would be likely to strike (where permitted), a mistaken assumption' (Bailey & Trinder, 1989:28).

If there was a 'model' in the mind of the RCN with regard to pay review, the DDRB must have been the prime candidate. Doctors had long been viewed as having successfully professionalised their occupation and pay review may have been regarded by nurses as one of the rewards

for this success. However, the operation of the DDRB has been controversial. The DDRB was originally established in the early 1960's by the Conservative government after a period of industrial unrest over pay. It was subsequently notable for the resignation en masse of its members following the reference in part of their 1970 recommendations to the NBPI. The DDRB was reconstituted in 1971.

During the 1970's the DDRB largely recommended increases in line with incomes policy in those years for which this operated. With respect to any suggestion that the earnings of the two professions were being used as an economic regulator, however, the DDRB was adamant that it would apply judgements only if it was convinced that incomes policy was being fairly applied to doctors and dentists and that their earnings were not falling behind comparator groups. In 1977, the DDRB decided that a deterioration had occurred as a direct result of the unfair application of incomes policy, and went on to rectify the position in the 1978 award, which was staged over three years. The relatively limited use of 'refined' comparability in practice is evident in the comments made by a research officer for the BMA, to the effect that the lack of detailed information which was available for comparisons, and the need for this 'rectification' in the first place, 'demonstrated the extent to which the DDRB's methodology had departed from the Royal Commission's original guidelines', which had stressed external comparison, and the fact that doctors and dentists should not be used as an economic regulator (Ford, Health Services Manpower Review:7). The last time the exercise of comparison had been conducted was in 1972 when movement over the whole period since 1955 had been examined.

In the 1980's there was a general shift in the rhetoric of the DDRB's process to an explicit emphasis on the 'ability to pay' criterion, probably not unconnected to the Health Departments' insistence that pay comparisons should not be used as the major factor determining pay levels. By 1991, economic considerations (or ability to pay) were placed at the forefront of the DDRB's report, followed by recruitment and retention, morale and motivation, job security, comparisons,

workload and productivity, pensions and internal relativities. However, although the DDRB frequently reiterated its view that there should be no fixed linkage of doctors' and dentists' earnings to any particular measure of other remuneration levels, the DDRB often took broader measures of comparability into account, such as the RPI and general levels of earnings elsewhere. It was also loathe to suggest that it no longer regarded comparability as a relevant factor although the significance it attributed to comparability tended to vary periodically and with political expedient. In 1987, external comparisons were viewed as not 'irrelevant to our work' (DDRB, 1987:5); in 1991, comparability was elevated to 'one of a number of important factors with respect to the decline with the private sector' (DDRB, 1991:7)

In terms of outcomes or government implementation, the staging of awards was a common occurrence. Most of the 1980 awards were staged, as was the 1990 award. Regret at such staging and its adverse effects upon the credibility and stability of pay review has been expressed in most of the PRB reports. The 1987 report, for example, noted that:

deferment of pay increases has adverse effects on the credibility of the Review Body...It seems to us that the Government has in practice abandoned the traditional principle that our recommendations should be accepted unless there are clear and compelling reasons to the contrary. The Government's actions since 1980 imply that our role is to distribute a pre-determined allocation of funds, and we cannot believe it was ever intended that the Review Body should be thus confined. (1987:1)

Significantly, industrial action was not always avoided. Moreover, it is almost certainly the case that the process and outcomes of individual awards were influenced by the relative intensity of the professions' feelings and the degree of electoral vulnerability of government, even when direct action was not proposed or taken, although these factors are harder to quantify. Most recently, the DDRB declined to produce a Report after the government's announcement of a 1.5% pay limit for the public sector.

The review body for the Armed Forces (AFPRB) by comparison, has what might be viewed as a quite different group of staff under its remit. Unlike doctors, the armed forces are not unionised and offer quite different strategic considerations. These differences may in some respects be reflected in the relative strength of the comparability criterion, and the inclusion of a special 'X' factor designed to take account of the special nature of the armed forces' work (a cost/benefit calculation vis-a-vis civilian occupations which includes an adjustment for 'danger and turbulence'). Comparability, through factor analysis, has, in contrast to the DDRB, remained the 'basis of its approach' (AFPRB,1991:1). Other criteria considered have included recruitment and retention, the Defence budget and the ubiquitous 'ability to pay' criterion in the form of 'general economic background'. However, in common with the experience of the DDRB, staging or delays have taken place several times.

The Top Salaries Review Body (TSRB) addresses yet another politically and electorally sensitive group of staff, as was witnessed by the Government's desire to avoid high increases in the review exercise immediately prior to the General Election of 1992. The Reports generally contain far less detail on criteria than the other Review body reports, perhaps reflecting the small number and high status of this group and its relative proximity to government. However, like the DDRB it has been ambivalent on the comparability criterion. In its 25th Report, the TSRB expressed 'serious doubts as to the extent to which the rise in earnings for outside groups should influence our judgement' (1987:9). However, a comprehensive review of salary structures and levels was undertaken in 1985, and there are indications that comparability re-emerges periodically after periods of fall-behind in pay. The 1991 TSRB, for example, announced plans for a 'fundamental review' due to 'erosion of relativities' with comparable groups elsewhere. This was to be by means of a job evaluation, along with comparability exercises with the private sector and international comparisons (1991:3). Scaling down and staging has also taken place for the TSRB.

According to Bailey & Trinder, the Review Body concept was developed because 'it was assumed that this would resolve acrimonious negotiating relationships, inject stability into pay determination and allow account to be taken of financial constraints' (1989:28). On the evidence from this brief history of the practical operation of review bodies, it is not clear that the conceptual basis for pay review elaborated by Bailey and Trinder has been fully met. Firstly, it is difficult to judge whether industrial unrest is avoided, channelled or merely suppressed by the operation of a PRB, given the highly particular nature and background of these groups. The indications are that, at least in the case of doctors, industrial action has not been prevented at all times. Profound dissatisfaction is expressed at times in evidence by the other staff groups. The particular nature of other groups, especially judges, senior army officers and civil servants, means that dissatisfaction may, in any case, be expressed through less formal channels and pressure applied behind the scenes.

Secondly, there has been an ambiguous treatment of the 'ability to pay' and 'comparability' criteria within and across the Review Bodies and even where ability to pay has been made an explicit emphasis in process, comparability still comes intermittently to the fore again as wages fall behind, staff groups feel aggrieved, and there is a need to demonstrate 'fairness'. More pertinently, it is difficult to separate out rhetoric from recommendations given the general claim of RBs not to be bound to any 'mechanistic formula'. Thus, and despite some increasing emphasis placed on the ability to pay criterion, along the lines advocated by government and Management Sides, the precise effect remains unclear: another form and content problem. However, the same problem, in terms of interpreting process and outcomes, was argued for other systems of arbitration and review and could be seen in the case of the DDRB to apply in the 1970's where the evidence suggested that attempts were made to fit into explicit incomes policies.

In practice, outcomes for the 1980's may also be viewed as exhibiting a degree of compliance with implicit incomes policies (via the cash limits mechanism). None of the Review Bodies has been allowed to

operate in such a way that 'fall-behind' and 'catch-up' periods have been averted in favour of long-term consistency and stability of pay awards, which was part of the rationale for PRBs in the first place. This is an important point for nurses and midwives, who as we have seen have had a long history of such pay cycles since the establishment of the NHS. It has not been the case that Pay Review Bodies produce recommendations which are unproblematically accepted by the government. Recommendations may be scaled down, staged, and partially, rather than fully, implemented. Furthermore, funding in full or in part may be provided above the amount the government 'allows for' in previously set cash limits. Government decisions on implementation and funding have, in part, helped to produce outcomes which have tended to reflect ability to pay, or perhaps more appropriately, willingness to pay. Bailey & Trinder have argued that 'few settlements have been excessive relative to others in the public sector in a given year' (1989:29), although they go on to suggest that nurses form the main exception to this rule. However, yet again, it is not easy to distinguish between the role of process and implementation in producing this effect. In conclusion, it is debatable whether 'acrimonious relationships' have been resolved and 'stability' injected into pay determination although there is some evidence that 'account' has been 'taken of financial constraints' both in the process and outcomes of the Pay Review Bodies.

CONCLUSIONS

This chapter has traced the origins of the Nurses' and Midwives' Pay Review Body in the twin strands of prior arbitration and review in nursing pay determination and the establishment of Pay Review Bodies for other groups in the public sector. The analysis of structures, processes and outcomes of these forms of review, and the arguments raised in the initial consultations on the establishment of the N&M PRB, now allow some preliminary theoretical conclusions to be drawn on the rationale for, and role, of pay review. This will lead in to the detailed examination of the process and outcomes of the Pay Review Body for nurses in Chapter Four.

With the recent establishment of a Review Body for 450,000 teachers, a million and a half workers, some quarter of public sector employees, now have their pay determined within the Review Body system, the largest group of staff covered being nurses (Guardian, 25 October 1992). Yet there has been relatively little academic comment on the rationale for such a system of pay review, either in general or for the particular case of nurses. This stems, at least in part, from the apparently ad hoc and pragmatic nature of the establishment of pay review mechanisms in general and pay review bodies in particular. Yet the above discussion has suggested that some commonalities in the operation of pay review and pay review bodies can be found and should have some relevance for wider theory.

Ostensibly, pay review is a liberal concept. Taking the rationale for pay review bodies firstly at face value, it will be recalled that the Pilkington Commission identified three main objectives for pay review bodies: to avoid disputes over remuneration; to provide an assurance to staff that their pay would be determined on a fair basis; and to provide fair treatment for the taxpayer, the latter generally construed as 'economic and financial considerations' (see Bailey and Trinder, 1989:28). However, a number of problems arise with this concept. Firstly, the objectives in the statement are conflated with the means to, and constraints on, achieving them: fairness to staff is a means to achieving the avoidance of disputes, and fairness for the taxpayer the constraint on these means. It is by no means clear what a compromise position in material terms between the latter two points might entail or how it might be attained. The achievement of the primary objective of avoidance of disputes could therefore be seen to be more an article of faith than a 'rationale' for review bodies.

Secondly, it is notable that the industrial relations imperative is placed in primary position and this, indeed, appears to accord with the historical facts around the establishment of review bodies. However, the notion that overt expressions of conflict are undesirable and avoidable, whilst symptomatic of liberal pluralist analysis, begs the question of why conflict arises in the first place. In this case,

pay review addresses the symptoms - the apparent failure of collective bargaining - without addressing the root cause of why it fails.

Finally, problems also arise with the liberal, pluralist view of the role of pay review bodies. Here the potential is seen for a 'neutral' third party to intervene to channel conflict into manageable compromise whilst simultaneously effecting a 'rational' balance between differing material interests. However, the problem here lies with the argument for 'neutrality'. It is by no means clear why the review body should assume in this respect the role that government, in pluralist political theory, should have been able to take on itself. There is an implicit recognition that government has been unable to perform the role of impartial arbiter where it is also employer and must thus create an 'independent' arbiter from itself to do this. Again, however, it is by no means clear why this body should be impartial whilst government could not be, particularly given its direct appointment by government and lack of representativeness and accountability. In all these respects, the neglect of power and power disproportionalities and the neglect of a deeper evaluation of the role of the state and of industrial conflict cast doubt upon the analytical power of this perspective to convince of the rationality and viability of pay review bodies.

Recourse to either pluralist theory or arguments of 'pragmatism' provides little explanation for why government has proceeded to set up a de facto 'institutional blockage' to the free working of the market, whilst simultaneously professing a deep ideological attachment to radical versions of neoclassical 'market forces' theory. There is, therefore, much to recommend an alternative, and more radical, approach, where power disproportionalities and conflict over terms and conditions of work are viewed as endemic to the productive system and a primary point of analysis. It has been seen that nursing pay determination has long been characterised by conflict and power disparities. The post-World War Two history of arbitration and pay review has witnessed ever more complex mechanisms of pay determination, tending eventually to the 'supplanting' end of the

'supplementing-supplanting' spectrum of arbitration and, in theory, replacing 'free collective bargaining'. Broadly viewed, arbitration and pay review have appeared to temporarily paper over the cracks in the Whitley system. These cracks need, however, to be located in context. It was seen in this chapter that nursing trade unions have long argued that the problem lies not in having a collective bargaining system but in the disproportionate influence of government and poor material outcomes in pay determination. Under these circumstances, the ability of a permanent form of pay review to resolve basic conflict would remain at doubt.

This point is further elaborated in the analysis of Pay Review Bodies for other public sector workers. There is little evidence that 'conflict' has been resolved, even given the unusual nature of these groups, or that pay 'stability' has been achieved. Moreover, a certain correspondence emerges between process and outcomes and the government's ability to pay. The institution of pay review must here be seen as playing a mediating and material role. All the PRBs were set up under Conservative administrations and have been conservative in their operation and outcomes. Their structure is that of an unelected, unrepresentative, unaccountable body. The PRBs as a whole, with their interlocking memberships and terms of reference, span groups of staff with considerable inequalities in pay. For example, wages in 1991 ranged from £6,050 (a young nursing auxiliary) to the top salary of £104,750 in the civil service and armed forces (basic, full-time per annum, Reports, 1991). Differentials in the 1980s have tended to widen, both within and between PRBs and arbitration and pay review exercises for nurses also saw widening differentials and a re-establishment of the traditional wage hierarchy after erosions by the nursing trade unions. The system thus appears to support inequalities.

It has been argued by Bailey and Trinder that there is a 'relatively tenuous degree of cohesion' between the groups covered by pay review (1989:29), and the attempt to explain coverage by 'professionalism' or 'likelihood to strike' is problematic. In practice, however, it could

be argued that these groups share a history of deeply hierarchical systems of work organisation which may make them more susceptible to a system of pay determination based on deference and derogation. The groups also share a high degree of political and electoral sensitivity and, in this respect, the system shares a strong hint of political expediency with its antecedents in arbitration and special review exercises. The PRBs may thus avoid head-on confrontation with government and key groups of employees and set disagreement at one step remove, enabling both 'sweetener' awards when necessary and the longer run and more general attempts at cost-minimisation. At an equally strategic level, the establishment of PRBs also divides staff in times of wider dispute and may further facilitate cost-minimisation.

In the above form of analysis, and from the history of pay review and the persistence of expressions of conflict, the particular role of and relationship between structure, process and outcomes, the extent to which accommodations are made through the pay review system, and the extent to which conflict is suppressed, channelled or diverted still remain empirical points. This is not least because of shifts in the power balance between government and public sector employees. Thus, although this chapter has lent some credence to the a priori expectation that review bodies are instrumental in maintaining the status quo, the extent to which this is achieved in practice becomes an empirical matter, which is now explored.

CHAPTER FOUR

THE STRUCTURE AND PROCESS OF THE NURSES AND MIDWIVES PAY REVIEW BODY

This chapter analyses the structure and process of the Nurses' and Midwives' Pay Review Body, from its inception through to the present date. In doing so the theoretical perspectives of the study are developed to show some of the complexities of nurses' wage determination through the PRB, while at the same time deepening the analysis of the functions of the review body itself. The underlying issues are then examined in further detail through subsequent chapters, following an exploration of pay outcomes in Chapter Five.

COMPOSITION

As Chapter Three notes, the Prime Minister appoints members to the N&M PRB. In this respect the new Review Body has followed the structured format of the Halsbury Committee and the other PRB's. Members are appointed for their 'individual qualities' and are intended to be 'completely independent' (Consultation Document, 1983). None should belong to, or be closely connected with, the professions whose pay is being reviewed. Members should generally serve for a period of four years but may then be reappointed for further terms.

It is not intended that the composition of the N&M PRB should directly reflect the composition of interests concerned in the process of wage determination, as would be the case in a tri-partite structure, and as was intended to be the case under the previous Whitley Council. The members are chosen exclusively and in a highly centralised fashion by one of the Sides to the process, the government. Throughout the period of its existence a substantial number of the Review Body members (particularly Chairmen) have been senior industrialists, with additional members drawn from academia, law and the church. A number have held high honours. Despite the gendered nature of nursing members have been predominantly male. Only in the ninth Review Body did the membership include more women than men.

Members selected in this way - drawn from the 'ranks of the great and the good', as one trade union official put it - are expected to rise above the partisan source of their appointment, putting personal backgrounds and experience to one side while overcoming any previous ignorance of the NHS and its nursing professions, and of public sector finance and macroeconomic constraints, in order to balance the scales of equity between taxpayer and public employee. In these circumstances what is perhaps remarkable is the degree to which members appear to be regarded as acceptable - at least by Staff Side. Despite some discordant notes in the nursing press (Nursing Times,1991:26), interviews with trade union officials revealed a common belief that PRB members become 'client-oriented' through time (see also in this context Bailey & Trinder,1989:29). It was widely held that members' sympathies for nursing staff increased through successive hospital visits and Staff-Side representations at the Oral Evidence stage of the Review Body proceedings. It was also noted that this tendency towards client-orientation appeared resistant to changes in membership, and in this respect at least few signs of government pressure in the PRB's actual decisions could be detected.

EVIDENCE AND REPRESENTATION

Written evidence is submitted to the PRB by all interested parties, and the PRB may request additional information or clarification in Oral Evidence. For instance, in the 1991 Report the organisations submitting written evidence were the Health Departments, Regional Authority Chairmen, and the Management and Staff Sides of the Nursing and Midwifery Staffs Negotiating Council, with the Staff Side's evidence being supplemented by submissions from COHSE, HVA, NUPE, RCM, RCN and SHVA. Evidence was also received from the National Association of Theatre Nurses and the Prison Officers' Association Central Committee for the State and Special hospitals, as well as from a number of individuals (PRB8,1991:43). In the 1992 Report the list of contributors expanded to include the NHS Trust Chief Executives. However, the evidence summarised in the PRB reports consists almost exclusively of arguments presented by government and Staff Side.

Following the Pilkington 'rationale', the government could be expected to represent the interests of taxpayers in forwarding evidence (see also N&M PRB,1992:9-10) [1]. However, it is by no means clear what the interests of taxpayers should be, even if the government were assumed to act without self interest. At the same time the government may indeed have its own party political interests and a self-interested economic agenda. As Staff Side have noted in the Consultation exercise, this may or may not include 'managing' the economy well. Moreover, different parts of government might pursue conflicting interests. The different tiers of NHS management - at senior, district and local levels - might also have sectional interests. A similar distinction could likewise be made for the varying interests of the Staff Side professional associations and unions. Finally, the PRB members themselves could have collective or individual interests which conflict with those of the other parties.

The PRB process largely consists of a dialogue between the government, or 'Management Side', and Staff Side. In this context it is not clear whether internal cohesion on each side - for instance, RHA Chairmen and Health Departments presenting a united front - should be interpreted as a strength or a weakness of the pay review system. At the very least it can be noted that the agenda upon which decision-making is based is limited from the outset by the groups involved and may be skewed by the particular composition of the sides and weighted in favour of the most powerful interests. Some interests may be excluded entirely from the process, and lower levels of management may be found in this category along with nursing and midwifery staff who have relatively weak influence on Staff Side's joint representations.

A substantial amount of evidence is produced for the PRB process. Staff Side and the Health Departments may each present Evidence amounting to one hundred pages and containing a great deal of

[1] It is strange that the PRB makes a distinction between 'taxpayers' and 'patients' in what is, in principle, a universally-provided healthcare system (PRB,1992:9-10).

statistical data. Additional evidence may also be lengthy and contain highly detailed information on change occurring in the various staff occupations and the results of special surveys conducted for the review exercise. A trade union officer, involved in this process for many years, suggested that the various nursing representative organisations competed for the prestige generated by such surveys. These surveys were also seen to carry additional benefits in their potential to engage memberships in the pay process while demonstrating the work conducted on their behalf. The production of evidence casts doubt on the proposition that the scope for trade union activity has been reduced in the new system. However, the the actual effects of such evidence on the conduct of the review process and its outcomes remains an empirical question.

CLASSIFYING PAY CRITERIA AND ARGUMENTS

Following the presentation of written evidence Oral Evidence is taken. The evidence as a whole is then summarised in the PRB's Report, albeit with a high degree of discretion on the part of the Review Body as to what is included or excluded. Recommendations then appear at the end of the Report. However, the manner of adjudication has caused much difficulty in evaluating the PRB's role in the pay determination process. In its first report the PRB stated that:

The problems which need to be resolved in order to produce a stable system of pay determination are complex and wide-ranging, and we are convinced that there is no simple, mechanistic approach which we can apply (1984:15).

Correspondingly, the Review Body's reports contain no explicit rationale or methodology by which to appraise its normative decisions.

The debate conducted within the forum of the PRB itself has centred around a number of criteria. Firstly, there are what may be termed 'core' criteria, which address the issues of basic pay, special duty payments and allowances. Secondly, there are what may be described as 'ad hoc' criteria, encompassing issues arising from recent change, such as the restructuring of grading systems or the introduction of

flexibility initiatives. Developments in the type and choice of criteria employed in the process demonstrate some marked similarities with conventional negotiations, in as much as each Side has developed its own agenda and introduced new items in an attempt to gain the higher ground. The material contained under these criteria has therefore been organised to reflect this, and to illustrate the differing positions held by the Sides and the manner of the PRB's own involvement [2].

It was seen that in the Consultation exercise the government attempted to set the actual agenda for criteria to be considered by the PRB, later moderated in the PRB's Terms of Reference, to note that the government would itself:

submit evidence on economic and financial considerations, and on such factors as recruitment, retention and motivation of the staff concerned (Appendix A, PRB1, 1984 from House of Commons Written Answer, 27 July 1983).

Although this left a relatively clear role for the new PRB in setting its own agenda, it can be seen that the government's priorities in wage determination criteria had moved substantially away from the rhetoric, if not the reality, of the Pilkington objectives. These had very explicitly included the notion of fairness to staff as well as to taxpayer and therefore, implicitly, the importance of comparability. This point has been used in some of the more recent literature as an illustration of the government's retreat from its traditional role as 'model employer' (see Fredman & Morris, 1989a, 1989b). However, it is unlikely that the government had a serious strategy to establish an operating PRB which would deny the use of the comparability criterion while still gaining acceptance from nurses' organisations. Rather the

[2] Basic pay has remained fairly constant at around 85.5% of the overall paybill, with special duty payments declining in relative importance (from 12% of the paybill in 1984 to 10.5% in 1989) and allowances growing in importance.

TABLE 4.1 GOVERNMENT AND STAFF SIDE AGENDAS FOR PAY REVIEW CRITERIA

<u>GOVERNMENT AGENDA</u>	<u>STAFF SIDE AGENDA</u>
Macroeconomic policy	Comparability
PSBR - cash limits	Equal pay
Staff recruitment/retention	Low pay
Staff morale	Differentials
Efficiency/productivity	Productivity
<u>UNDERLYING ISSUES</u>	
Demand/employment	Demand/employment
Grading, Training,	Grading, Training
Skills, Flexibility	Skills, Flexibility

view could be taken that this was a tactical device to 'skew the agenda', ostensibly towards orthodox economic concerns and objectives, thereby signalling government toughness while leaving the PRB some scope to express sympathy with staff aims.

In any event in the PRB's first report (under 'Views of Main Principles') the Health Departments (HDs) stressed recruitment and retention and how much the Health Authorities (HAs) could afford to pay as being of primary importance. By contrast, Staff Side (SS) stressed four key principles which they thought should guide the Review Body in establishing fair levels of pay: fair relativities or comparability; fair internal differentials, with staff being 'properly rewarded for their qualifications, responsibilities and experience'; pay not to be less than a minimum level which would provide an adequate standard of living - the low pay issue; and pay not to be depressed by the fact that the majority of nursing staff are women - the equal pay issue (PRB1,1984:8). These polarised initial 'agendas' for criteria to be considered are illustrated in Table 4.1, together with the additional 'neutral' criterion of Productivity which was introduced in the first Report's deliberations.

In both cases there are important underlying issues which do not enter directly into these criteria, but which affect both core criteria and the emergence of ad hoc criteria, for example, grading and training. Such issues overlap with wage determination, but have been largely negotiated or decided outside the PRB process.

Salamon suggests that wage determination criteria can be interpreted as representations of equity when seen from the individual perspectives of different interest groups (1987:458). However, this presupposes the existence of coherent interest groups with well-defined views of equity. At the same time it also ignores intrinsic limits to the representation process for the Sides involved in pay review. Each Side might be expected to advance a set of consistent arguments in order to win well-defined material outcomes. However, in practice arguments are advanced in order to win tactical advantage for an underlying agenda and as a general bargaining tool. The form these arguments take will then reflect institutional settings and existing power disparities and should not simply be taken at face value.

Given the complexity of public sector wage determination and the problems this raises for economic theory and the analysis of equity, the development of a consistent set of arguments to be advanced by a Side in the pay review process is a considerable undertaking. With the 'skewing' of the agenda towards 'economistic' criteria Staff Side have exhibited a steadily-increasing sophistication in posing the issues of economy and equity. Contrary to the expectations generated by the standard literature on wage determination, this has not in practice entailed a simple contrast between economy and equity, but rather a systematic attempt to reveal basic complementarities.

The debate has gradually focused on recruitment and retention as the key criterion in pay review. This debate subsumes both the tactical ploys of each Side and Staff Side's historical concern with the progress of nurses' comparability with other groups. Although the argument is still broadly dominated by considerations of tactical advantage and political expediency, it is possible to identify within

the pay review proceedings the effects of underlying conflict arising from perceptions of pay and conditions of employment.

The Review Body reports contain no explicit rationale or methodology by which to appraise normative decisions on pay. This can be viewed as a strength or a weakness of the PRB itself in performing its functions. On the one hand, criticism of the route whereby the Review Body arrives at its decisions is necessarily muted. *At the same time* there is no need for the Review Body to maintain the projection of a normative 'ideal' in settling wages, thereby providing increased scope for the accommodation of interest group pressures. On the other hand, there remains the attendant risk that the review process itself becomes discredited, or that the PRB loses status as an 'independent' body mediating conflict between the Sides.

ECONOMIC AND FINANCIAL CONSIDERATIONS

The 'affordability' criterion has appeared in all the PRB reports, with the sole exception of the fifth report, an omission which may have been tactical as PRB5 was dominated by the impact of the clinical grading review.

The Health Departments initially saw 'how much Health Authorities could afford to pay' as the second most important criterion after recruitment and retention (1984:8), their basic premise being that neither justified substantial increases in pay. However by the 3rd Report, 'affordability' had been elevated to the 'overriding constraint of affordability' and they pointed to a 'direct and inescapable trade-off between increases in pay and the amount and quality of health care provided' (1986:5). An argument has been made throughout for an explicit cash limit on incomes. For example, in the 6th report, the HDs, under questioning, admitted that the percentage allowance for inflation provided for in HA's budgets was what they had in mind when saying that the real value of salaries should be maintained. Their agenda has become even more explicit in later years. In PRB7 (1990:6), the HDs said that:

The Government's objective was to keep the rate of growth of public spending below the rate of growth of the economy as a whole, and thus to reduce public spending as a proportion of national income.

The Minister for Health told the PRB in oral evidence that:

Modest pay increases in the public sector were essential if inflation was to be brought under control, and nursing staff would suffer like everyone else from rapidly rising inflation (ibid).

These remarks indicate the degree of government's influence over the Management Side, while providing an unusually explicit statement of a prevailing attitude towards the public sector in the macroeconomy. This has immense implications for the debate over the 'government as model employer' (for instance, see Fredman & Morris, 1989a, 1989b).

Staff Side have responded to 'affordability' arguments throughout by stressing comparability, since in their view external pay comparisons subsume the wider economic situation. In other words, what the nation can afford to pay other workers should be the guide for nursing staff pay determination. This was the first of many occasions when Staff Side followed the government's agenda and expressed their arguments in 'economic' terms. It is noteworthy that Staff Side have appeared to receive a more sympathetic hearing from the PRB when presenting evidence in these terms, perhaps because the PRB itself has an 'economistic' bent. Staff Side have further pointed out that the government's Autumn Statement cash limits allowance for inflation is frequently based on forecasts which underestimate subsequent price increases (PRB6, 1989:5-7). The affordability criterion has also been used to criticise the staging of awards and funding arrangements made on an historical basis rather than by establishment.

The PRB in early years responded in fairly strong terms to the government's emphasis on affordability:

We recognise that the implementation of our recommendations may cause resource problems...but it is the Government's responsibility to consider the implications for funding and the level of service that can be afforded, given adequate rewards for staff.

In particular it has stressed its view that:

the the community cannot expect to sustain and improve the quality of health care at the expense of those providing it...in view of the heavy dependence of the NHS on the ability to attract and retain suitable and well-motivated staff, such an approach would be self-defeating (1986:14).

The PRB has also remained unimpressed by the argument that nurses' pay can cause wage inflation; 'over the years we have had little if any evidence to demonstrate that our recommendations have directly affected others' settlements' (1992:10).

In recent years this approach has become more muted. The PRB has noted that economic and financial considerations are 'important factors' but that 'they do not override all others' (1990:6). The PRB's 'adjudications' do in fact tend to vary with time and this may be an important indicator of underlying pressures.

The ability to pay argument is not a new one; similar arguments have been made from the establishment of the NHS (see Abel-Smith, 1960; Clegg & Chester, 1957). What is possibly different is the degree to which this criterion has been pre-empted by tight cash limits, explicitly stressed as a priority in the pay determination process - even to the extent of a non-funding threat - and followed through in implementation and funding activity. As the PRB note, the 'economic' argument is, in its own terms, weak. If the government were to stress macroeconomic aims above all else, then it is not clear how it could meet its recruitment and retention objective. However, the more explicit use of this argument may best be interpreted as tactical manoeuvring. By stressing macroeconomic objectives, the government has attempted to pull the agenda over to the point at which it might 'legitimately' argue for low pay increases and assert an income-employment trade-off. It also sets the debate in 'economistic' terms.

That the PRB has felt compelled to counter this argument could be evaluated as reflecting its own interpretation of its remit as being primarily concerned with ensuring adequate supplies of staff rather

than macroeconomic equilibrium. Perhaps more importantly, it could reasonably be expected that an overt preoccupation with cash limits or attempts to use the public sector to control the private sector and economy more generally would have put the continuation of the PRB system in some doubt.

EXTERNAL COMPARABILITY

In response to the affordability criterion, Staff Side have taken up a 'proactive' position on the issue of comparability. Comparability is usually defined in narrow terms to denote the comparison of a group of staff which is 'internal' to an organisation with other distinct groups of staff external to the organisation (see Salamon,1987:465-6). In practice, a much wider range of issues has entered under this criterion in the PRB process, and correspondingly the definition of comparability is broadened to encompass a wider set of comparisons (including Kessler's notion of 'general comparability',1983:93).

Staff Side Arguments

In their evidence for the first report Staff Side identified comparability as one of the four key principles which should be used to establish 'fair' levels of pay, and submitted statistical comparisons in support of the argument that the pay of nursing staff had fallen behind that of selected non-manual occupations or non manual earnings as a whole (1984:8-9).

In subsequent reports, Staff Side have similarly presented a range of evidence and arguments to establish the relative deterioration of nurses' pay. They have compared current pay levels with the levels established by a particular past pay exercise (for example, Halsbury, in PRB3, and the initial real levels set for the clinical grades, in PRB7,8). They have also argued that the RPI might underestimate the impact of inflation on householders' budgets of rises in housing costs and food prices, which would particularly affect households with low incomes (PRB8). Comparisons have also been produced from NES data

with the pay of policemen, firemen, teachers, social workers and laboratory technicians (PRB5, 1988:12, PRB7, 1990:6), with the proviso that as the pay of some of these professions had been held down in certain years, the PRB should also look at the salaries of graduates in industry. Staff Side have also produced a number of surveys, suggesting the need for pay increases. For example, COHSE's survey in PRB8 showed that 62% of respondents believed that pay was neither 'fair' nor 'adequate'.

Staff Side have also attempted to establish the importance of comparability and stressed that recruitment and retention cannot be considered separately from comparability, particularly with the need to recruit more men and more school leavers. They have consistently argued that it is contradictory for the HDs to be averse to external pay comparisons while holding fast to recruitment and retention criteria. An example of this argument can be seen in the 8th report, where Staff Side argued that, particularly in the face of increasing workloads and the need for more staff, recruitment and retention would suffer if pay was allowed to fall back relative to that of other groups.

In this respect they have criticised the government for being 'short-sighted' in staging pay awards and rejected the HD's view that pay levels recommended by review bodies should set a trend for the rest of the economy. They have also countered the Departments' assertion that nurses recent pay performance has been better than other groups, suggesting that:

over the long term...pay levels had in general done no more than move in line with the labour market. Since the RB was established, pay levels were first stabilised and then raised (in 1988) to an appropriate level. Subsequent recommendations were intended to maintain relativities in broad terms, but they had not entirely succeeded because of the increase in inflation and the staging of the 1990 pay increases (1991:8).

From the point of view of future stability in pay arrangements, Staff Side have consistently argued for the establishment of a system of comparability and a pay data bank (PRB3). At the same time, they have

argued that they do not necessarily wish to see a fixed link between nursing pay and that of external comparators, nor to see other factors disregarded (PRB5). In this respect it should be clear that comparability is one of a range of bargaining tools and Staff Side would not wish to lose the ability to bring in other arguments.

Health Departments and RHA Chairmen Arguments

In the first report, the HDs took 'the view that comparability should not be the main element in pay determination but that it has some part to play' (PRB1). The meaning of 'some part to play' was clarified somewhat in the second report where it was suggested that it should play 'a relatively small part in determining pay levels', and that evidence on comparability should be 'treated with caution' in judging pay levels as 'other factors need to be taken into account in assessing the quality and weight of jobs' (PRB2, 1985:8). In the fifth report, the Health Departments drew attention to the need to contain costs within the public expenditure provision for the NHS and noted that comparisons were in any event highly subjective - 'the Staff Side in their evidence used those which best suited their case' (1988:12-13). By the 6th report, the HDs had decided that 'they did not regard external pay comparisons as particularly relevant to the interests of the NHS' and suggested that 'recruitment and retention should be the major determinants of pay levels' (1989:8). They accepted that market comparisons could be an indicator but that such comparisons should be local, with reference to competing employers rather than to jobs determined as similar.

Their own priorities have been exhibited in their view that 'review body groups should not receive excessive pay increases, because of the influence they had on other groups in the public sector and elsewhere' (1989:8). The RHA supported this evidence, saying that 'the public sector should set a good example to others by not giving excessive pay increases'. These views were again strongly expressed in the 8th report. In the 9th report, Staff Side's production of comparisons on

a range of external occupations were deemed 'irrelevant' by the HDs (1992:9).

The HDs and RHA have thus largely responded to the comparability criterion by denying its importance and attempting to reassert their own 'ability to pay' criterion as the primary priority. They have further suggested that local 'market forces' should be allowed to work themselves out through the activities of local employers, emphasising demand-side solutions to any nurse shortages. The HDs have been very resistant to comparisons with Halsbury and pointed out a number of weaknesses in the Halsbury Report's recommendations on relativities, as well as arguing that historical comparisons depended entirely on the choice of base date (1984:9-10). However, and despite these criticisms, the HDs have also produced comparisons in support of their own view that nurses pay is adequate. These have mainly compared the movements rather than levels in nurses' earnings (for example, increases in real pay) and used gender specific comparisons (1985:9). In their comparisons with other NHS staff, the HDs have shown particular concern that differentials should not widen between ancillary staff and nursing auxiliaries (PRB3).

The PRB's Discussion of Comparability

The PRB appears to have taken a cautious and incremental approach to the comparability criterion and their first step was to commission a number of surveys to illuminate particular questions. These included comparisons conducted by the OME, based on entry qualifications and training requirements, which showed average salaries for nursing students and staff nurses to be lower than comparators (PRB2), and surveys of pay and conditions in the private sector (covering occupational health nurses in industry and nursing staff in private hospitals), which did not show a wide discrepancy between the two sectors. It may be noted in passing that comparisons with the private health sector fail to take account of training costs borne by the NHS, given that the private sector largely 'poaches' from existing stocks of qualified and experienced NHS nursing staff.

The PRB has generally responded to Staff Side's proposals for a system of comparability by suggesting there would be problems with methodology and that a study of internal job relativities should precede any study of external comparisons. The clinical grading review, for example, would provide a detailed study of jobs within nursing which would have to be an integral part of any study of external comparisons (PRB3, 1986:16, PRB4,1987:15)). In this respect, it was initially suggested that any full measure of comparability would have to await internal review. In the 6th report, following suggestions by Staff Side that the external comparability exercise could now be undertaken, the PRB concluded that there was no evidence that an agreement by the Sides would be forthcoming to undertake a full comparability study (1989:8).

However, the PRB has appeared to take some note of Staff Side arguments. For example, by the fourth report, the PRB stated that it had taken comparability into account because:

this year a changing picture has emerged. We have already indicated our view that, if the developing manpower problems are to be tackled successfully, it is necessary for pay to be adequately competitive. The comparisons we have made tend to confirm us in the conclusion that this is not at present the case.

In the 5th report, the PRB concluded that their impression was that 'levels of remuneration for most nurses are still relatively modest...the evidence available to us does not lead us to think that adequate competitiveness has yet been achieved' (1988:13). In the 7th report, the PRB gave the clearest expression of its position. It did:

not consider that external comparisons are the main factor that we should take into account in making our recommendations, but neither do we think that they can be ignored. We believe that general information about external pay levels and movements is helpful in providing an indication of levels and trends in remuneration in relevant labour markets. Competition for staff from other employers is increasing...We conclude that there would be unfortunate consequences for the delivery of health care were the NHS to fail to be sufficiently competitive (1990:7).

Despite its rather ambiguous stance on the significance it attaches to comparability, the PRB has been fairly critical of the HDs' general

arguments on the 'comparability' criterion. It has also been critical of some of their more specific points. The PRB has occasionally queried the selection of the base year made in the HD's own comparisons, which may appear somewhat ironic in the context of the HD's remarks on Staff Side comparisons. It has also appeared to reject the HDs concern with the widening of the gap between ancillary workers and NAs, arguing that:

the gap between the two groups is not significant nor nearly as wide as the Health Departments have suggested. In any event, the pay of NHS staff outside our remit is not our responsibility. We do not ignore what is happening elsewhere in the NHS but it would be wrong for us to recommend what we might consider to be inappropriate salary levels for nursing staff because of anxieties about possible knock-on effects elsewhere (1986:19)

It can be noted that this view contrasts strongly with opinions expressed in interview by some union officials. These officials felt that the PRB's concern with such relativities had been one of the primary motivating factors in the PRB's deliberations, and this begs the question of the PRB's methodology in reaching its actual decisions as opposed to the views it expresses in reports.

General Comparisons

Cost of living, despite its high significance as a criterion in wage determination in the economy more generally (see Millward et al,1992:238), has received relatively cursory treatment in the pay review process for nurses, appearing mainly under comparability arguments, although this should not suggest it is unimportant. Its practical usage in the review process raises questions about its treatment in academic literature where 'real wage' arguments are often listed as distinct from 'comparability' arguments (see Salamon,1987:463-8). Although certainly conceptually distinct, the linkage between cost of living and comparability is a strong one - unless workers are viewed as having little or no perception of settlements elsewhere in the economy. If, for example, a group were to obtain a 2% real wage increase whilst real wage settlements in the rest of the economy were running at 200%, then a comparability

argument evidently pertains. Similarly, the average earnings index is usually used to establish how one group is doing compared to workers more generally. Cost of living and comparability may certainly be argued separately for tactical reasons and the argument that a staff group should not have spending power reduced because of inflation, which may be beyond their control, may make a strong 'moral' argument. However, it may again depend for its force on what is happening elsewhere - the 'acceptability' of the 1993 public sector pay freeze may be an interesting example.

In the first report, Staff Side presented data to show nurses' real pay had fallen since 1975 and claimed substantial increases to restore the real pay levels awarded by the Halsbury Inquiry and the Standing Commission on Pay Comparability. The HDs thought 'it would be mistaken to determine current pay levels by selecting a particular past level of pay and updating this by some form of indexation' (1984:9), although as was demonstrated above, they have conducted such exercises themselves. In the second report, the PRB used the retail prices index, along with the index of average earnings and New Earnings Survey, to 'throw light on broad long-term relativities' (1985:16). This formed the pattern for subsequent reports though indices have been discussed under various criteria: the expected inflation rate was included under Economic and Financial Considerations in PRB6 and, in PRB7 and PRB8, price indices were directly subsumed under 'pay levels and movements, and pay comparisons'.

Taking the scope of comparisons one step further, the feasibility of international comparisons on pay levels was raised by the PRB (PRB1) and comparisons were made with Europe and the USA. Their relevance was found by the PRB to be 'limited' owing to dissimilarities between countries, particularly in the structure of nursing. It was also felt that 'meaningful comparisons' would require collection of information on a range of other factors in the countries concerned (PRB2, 1985:11-12). There has generally been a consensus that this is a problematic exercise (1986:13). However, the growing numbers of nursing staff

leaving to work abroad (reported in PRB5 under Recruitment) and the labour mobility implications of 1992 and the EC suggest that this issue is likely to come up again in the future.

Finally, non-pay issues have also been used for general comparison. The HDs argued in the first and second reports that job security should be evaluated as an offsetting factor to external pay comparisons (1984:10). Staff Side countered this by suggesting that by undertaking professional and relatively unmarketable training, staff made a long-term commitment and that job security was a necessity for a service which expended valuable resources on training and needed to develop skilled manpower resources in the light of growing demand (1985:11). The discussion raised the point of whether nursing skills can be regarded as 'general' or 'specific'. If, as Staff Side argued, they tend mainly towards the latter, then, in orthodox economic theory (see Becker, 1964), nursing students should not be expected to contribute disproportionately towards their training costs. The implications for students' pay are interesting. Pensions have also emerged as points for general comparison (PRB2) but, following the PRB's specially commissioned survey, nurses' pensions were found to be worth only a little more than the average private sector arrangement. The PRB did not appear to regard either comparison as particularly significant for its deliberations.

General Comparability: Low Pay and Equal Pay

It was noted earlier that Staff Side made low pay and equal pay two of their main principles for the pay review process. Low pay and equal pay are almost invariably used in a relative sense and as such can be classified as special cases of general comparability. Staff Side have mainly used the force of moral or equitable arguments under these criterion but have sometimes used economic arguments, or criticisms of these, where feasible.

Staff Side in PRB1 stated that 'pay should not be less than a minimum level which would provide an adequate standard of living' as one of

their four key principles (1984:8). Although this is an argument about absolute low pay, their evidence has usually drawn from statistics on relative low pay or has contained a strong implicit element of comparison. In the first report, the Staff Side noted that more than a third of full-time nursing staff earned less than £100 per week (from April 1983 figures in the NES). COHSE and NUPE subsequently put forward proposals which would give proportionately greater benefit to lower paid staff (1984:10). The Council of Europe Decency Threshold has also frequently been used as a measure.

Arguments on the existence of low pay have been supplemented by attempts to demonstrate the scale and significance of the low pay issue in other terms. For example, Staff Side have highlighted the prevalence of second jobs, following the IMS survey for the Staff Side which found that 16% of all nursing staff respondents had these - frequently as agency staff in the same hospital or district (PRB4). In the fifth report, Staff Side drew attention to the most serious low pay problems which were argued to be found among NAs, pupil and student nurses, and ENs, and to reflect the undervaluation of the nature of the work and responsibilities of these groups. Job descriptions collected for the clinical grading review showed that NAs made a significant contribution in most areas of work and had a large responsibility for basic nursing tasks. In the case of 50% of the NAs interviewed all or most of their work related to the care and treatment of patients. The review also found that many ENs had considerable responsibility with 30% being regularly or routinely in charge of wards. Staff Side argued that NAs and ENs provided stability on wards throughout Britain but that this stability should not be used as an argument that their pay was adequate. Staff Side felt rather that the experience and service of these nurses should be rewarded.

Staff Side have also drawn attention to measures to help the low paid in other areas of the public sector and have argued that the weight given to recruitment and retention in determining pay had worked against unqualified staff in the past as their mobility was more

theoretical than real. They have also suggested that the concept of a low pay threshold is not irrelevant and that wider comparisons are needed for these lower grades than differentials. Otherwise, such grades would be locked in to low pay because of the gender-specific nature of nursing and the fact that equal pay for work of equal value has not been achieved. The links between low pay and equal pay are here evident. In PRB6, PRB8 and PRB9, the section 'Low Pay' was notable by its absence, but Staff Side subsumed this under 'Clinical Grading' or fairness and comparability.

The HDs have generally failed to respond on this issue, which has largely consisted of dialogue between Staff Side and the PRB. When they have commented, they have stressed that pay should be at the level needed to recruit, retain and motivate staff, 'but no higher' and that the evidence on recruitment does not suggest that NHS pay rates are 'out of line' with rates elsewhere in the labour market (1986:12-13)

The PRB has expressed concern over specific examples drawn to its attention by Staff Side evidence. For example, in the 4th report, it reported that:

it is a matter of concern to us that, at a time of increasing workload and stress, such a high proportion of nurses, particularly but not solely in London, should apparently need to seek income from a second job (1987:18).

On the more general issue of low pay, the PRB has been more ambivalent. On the one hand the PRB appears to have 'fully accepted responsibility for lower paid workers who were within [its] remit' but still rejected any suggestion that it should be involved in helping to establish a minimum pay threshold for all workers (various reports). In 1992, the PRB stated that: 'we are not persuaded by arguments such as an appeal to the "Council of Europe decency threshold"' (1992:12).

Staff Side have achieved a degree of unity by the later years of the PRB on this issue which could be regarded as quite remarkable given the historical tensions between the unions and professional

associations and the effect that 'low pay settlements' could have on differentials. Their arguments have also evolved to include arguments which are more obviously 'economic' in nature and these appear to enhance their acceptability to the PRB. However, Staff Side have received relatively little response on this potentially important issue from either the HDs or the PRB.

In the first report, Staff Side stated that 'pay should not be depressed by the fact that the majority of nursing staff are women' as one of four key principles (1984:8). This was a broadly phrased argument for general comparability between nurses and external male wage levels. However, inevitably, choice of comparative measures are important and give different degrees of tactical advantage. Staff Side made a special push on this issue in the fifth report, arguing that the skills involved in nursing were undervalued because of their association with what had been regarded traditionally as women's work. The Staff Side then raised the question of equal pay for work of equal value and suggested that the 1984 extension of the equal pay legislation provided a basis for specific comparisons to be made between jobs done by different grades of nurse and other jobs in the NHS mainly done by men. They described comparisons they had made with jobs amongst craftworkers, ambulance staff and computer staff in the NHS and urged the PRB to undertake its own assessments of equal pay, failing which individual claims might have to be brought which would 'produce chaos in the grading structure'. NUPE also supplemented the evidence with a report commissioned from a specialist at Ruskin College which showed that the scope for equal value claims was wide.

The Health Departments believed that the Staff Side's examples 'showed claims under the category of comparisons with atypical jobs' and said that they would be more concerned if they believed that the pay system for nursing staff was 'vulnerable to internal claims for equal pay, against which they had tried to ensure'. The PRB concluded that if there were questions of equal pay to be resolved, the responsibility lay with the two Sides of the Negotiating Council and, with respect to clinical grades, with those responsible for placing staff on the new

grading structure (1988:13-14). In PRB6, PRB8, and PRB9, the issue of equal pay did not feature. In PRB7, Staff Side subsumed equal pay under 'low pay'.

That Staff Side's claims for equal pay were referred to 'negotiation' by the PRB perhaps again illustrates the real limits of the PRB pay process and the difficulty of getting 'equitable' issues taken seriously. Along with low pay, this was a potentially important criterion on which Staff Side have failed to make much progress, even though nurses constitute a clear case of both horizontal and vertical segregation. It is hard to resist the conclusion that the tremendous cost implications of both these measures must be as influential today in the relative failure of these criteria to get attention in the pay process, and in particular to encourage the government to take a more proactive role as 'model employer', as they have long appeared to be (see especially Wootton, 1955:130,153).

Some Conclusions on Comparability

The great variety of comparisons employed in the pay review process shows how important this issue is and how difficult it would be to imagine a process that did not involve such a criterion. The practical example from the nursing pay process illustrates that comparability arguments may stress either 'economic' or 'equitable' aspects as a matter of bargaining technique rather than as an expression of some underlying principle. Comparability may carry intuitive appeal for workers in that it appears to call for 'natural justice' or 'fairness'. However, the equitable aspects of this argument appear to have carried relatively little weight in the pay review process, though some issues have received 'sympathetic' treatment by the PRB. Staff Side have responded with tactical adeptness and explored the linkages with economic efficiency, showing that comparability is important for labour supply decisions. On this basis, the PRB itself has largely validated some usefulness for comparability.

The HDs have generally adopted what must be seen as a tactical stance of resistance to the use of comparability but have, nonetheless, produced evidence on comparability themselves where this is supportive of their own arguments. As with prior arbitration and pay review exercises for nurses, the HDs and the PRB have mainly undertaken gender-specific comparisons. The rationale for this has not been made explicit and is by no means clear although its implications are important for nurses. A more systematic appraisal of external comparability can be seen to have been subordinated to and delayed by the clinical grading exercise with an apparent subsequent unwillingness on the part of Management Side to agree to terms for this in negotiation or for the PRB to insist on it.

RECRUITMENT AND RETENTION

Given the polarised nature of the ability to pay and comparability criteria, and the historical significance of nursing shortages, it is perhaps not surprising that the debate shifted quickly and substantially to the recruitment and retention criterion. This has subsumed a wide range of 'economic' arguments and has in many ways clearly delineated the very limited usefulness of neoclassical theory for nurses' wage determination - and the NHS more generally.

The choice of recruitment and retention as one of three main criteria by the government was, with hindsight, possibly an ill-advised one. It may have been explained by their initial stance that there were no problems with recruitment and retention and that therefore no particular uplift in pay was warranted (1984:8). Little indication was given in the first report of the furore which was to follow and which has largely dominated the PRB process since. Despite all the problems of defining supply and demand in the area of healthcare, the Side which could establish a labour surplus or deficiency could legitimately claim an adjustment of pay on 'efficiency' grounds, within the scope of the 'economistic' agenda followed in the pay review process. Staff Side were quick to appreciate the potential tactical benefits.

From the outset, the problem of providing statistical evidence was raised. In particular, there did not appear to be any generally accepted way of determining what a nursing establishment ought to be. Recruitment is determined by the resources available to individual Health Authorities and therefore only recruitment and retention data for funded posts can realistically be determined. In this respect, the issue of recruitment and retention has raised wider questions about funding and volume in health service provision. Secondly, and quite apart from the issue of measuring 'demand' and 'provision', the criterion demonstrated severe data deficiencies in the NHS. The subsequent collection of data, though still widely regarded as limited, has been perhaps one of the most remarkable and little noticed effects of the PRB process. As data was collected, firstly by RHA Chairmen and subsequently by the OME, London regions and Staff Side, shortages were quickly established. For most of the period, shortages of qualified nurses were shown to be rising. As more precise measures were obtained, shortages of unqualified nurses were also established.

Health Departments Arguments

The Health Departments stated in the first report that recruitment and retention was the 'primary consideration'. Their view that 'recruitment and retention currently presented no major difficulty' was endorsed by representatives of NHS management (1984:8). By only the following year the HDs had revised this criterion to a secondary consideration (1985:5).

The Health Departments have subsequently been forced to moderate their arguments to take account of such shortages as have been established, and they have done this in a variety of ways. Firstly, they have tried to show that such shortages are not widespread or generalised. This argument has developed historically. In early reports, they attempted to show that vacancies were in specialisations or particular grades and that there were no shortages of unqualified staff (1985:7-12). In

later reports, there was an attempt to show geographical differences, particularly for London (1987:14-45).

Secondly, they have remained largely noncommittal about reasons for such vacancies and have consistently countered the proposition that generalised pay increases could be the solution. In this respect non-pay reasons and solutions have been emphasised, such as changing public attitudes to traditionally unpopular specialities (ibid). An extremely interesting part of the whole PRB process has been the nature and diversity of the so-called non-pay solutions suggested by 'Management Side'. These have included Skillmix changes and flexible rostering, Project 2000, pilot schemes for the use of the YTS as an entry route into nurse training, NVQs and support workers, provision of childcare, transport schemes, help with accommodation, various education and training initiatives, and measures to improve the management of nursing resources. Clinical grading was also seen as a measure which would aid recruitment and retention through the provision of proper career paths and the recognition of increasing levels of skill and responsibility. However, the evidence for pay-related reasons for shortages continued to accumulate and to gain some acceptance - at one stage RHA Chairmen admitted that pay could be an important determinant (1985:6). The HD's arguments then changed emphasis and it was suggested that shortages should be solved by targeted pay supplements, in particular through speciality and geographical supplements which were subsequently called 'flexible' pay supplements.

Thirdly, in response to a Staff Side emphasis on the longer-term problem of the 'demographic timebomb', the HDs came to acknowledge that this was a problem, but constantly repeated that they would prefer skill and geographical supplements to solve shortages rather than general pay increases. Finally, the Health Departments have attempted to demonstrate increases or adequacy in overall numbers of nursing staff, presumably to downplay the significance of such shortages as have been established. This has taken an interesting turn with the requirement to balance budgets prior to NHS Trusts and

subsequent events connected with the Trusts. In PRB8 this led the HDs in Oral Evidence, commenting on reports that some newly-qualified nurses had been unable to find jobs, to say that 'some health authorities had had temporarily to postpone recruitment and the opening of new wards in order to keep within their budgets'. This was an interesting admission, given the political sensitivity of this issue, but may actually have underestimated the closure of existing wards because of the cost of staff (see Chapter Six).

Numerous surveys have been conducted on recruitment and retention problems, and an interesting example of their interpretation by the HDs can be found in the fifth report. Here, an exceptional appearance was made by Regional Personnel Directors in the Thames regions, who suggested a variety of national and local reasons for shortages which included: demographic changes; pay and conditions; increasing workloads; apparent lack of incentives to return to nursing after a career break; high housing and travel costs; increased fears for personal safety; and loss of nurses to private hospitals, nursing homes and overseas (1988:3-5). One district had interviewed leavers, two-thirds of whom were Staff Nurses and forty per cent of whom were leaving the NHS altogether. The deciding factor for two thirds of those leaving the NHS was low pay (1988:5).

Whilst acknowledging that:

nursing and midwifery could no longer expect to satisfy the demand for staff solely by recruiting female school leavers with a minimum of 5 0 levels [given that] the number with between 5 0 levels and 1 A level was projected to decline by 25% by 1992-3 and there was no prospect of significant improvement before 2000.

The Health Departments nonetheless concluded that:

large across-the-board increases in pay would not be the most cost-effective way of responding to problems found in only some areas or specialities (1988:5)

The HDs instead stated that they would prefer a better-targeted approach using selective pay supplements (ibid) and emphasised non-pay solutions such as encouraging older people to re-enter nursing. Here,

the HDs pointed to the substantial numbers of qualified nurses and midwives not working in the NHS (1988:6).

The RHA's survey into factors affecting recruitment and retention, conducted by Price Waterhouse, found that pay was the main concern of all groups in the survey. Nonetheless, the RHA Chairmen drew the conclusion from the survey that the issues of pay were 'inter-related' with those of workload and management approach (1988:6). Most recently, the HDs have suggested that plans for improving standards of care do 'not necessarily demand more nurses and much could be achieved by improving productivity' (1992:7).

Staff Side's Arguments

Staff Side have put forward counter arguments to each of the arguments made by the Health Departments. They have pointed to the limitations of market forces theory for nurses yet, as shortages came to be established, have used 'economic' arguments where these are favourable. Staff Side have also conducted numerous surveys and have attempted, with some notable success, to put forward their own agenda on pay and non-pay solutions.

In response to the HD's assertion at that time that there were no shortages, Staff Side in the first report suggested that recruitment and retention needed to be considered alongside other factors such as morale, commitment and effectiveness, and noted that the current situation was affected both by the recession and by the fact that the Government could decide how many posts to fund in the NHS and had made manpower cuts (1984:9). They contended that the 'market forces' approach was inappropriate to the determination of general levels of pay for NHS nursing staff, since the majority of staff had made a long-term commitment and the NHS was a near-monopoly employer. In their view, both demand and supply for nursing staff were determined by political considerations. The level of demand was determined largely by the budget allowed by the Government and the supply of newly-trained nurses determined largely by the number of places

provided in schools of nursing. Moreover, market forces as such did not seem to play much part in determining pay in the private sector which continued to give significant pay increases even where there were no recruitment difficulties.

Staff Side also questioned the availability and reliability of statistics on shortages. With respect to the early surveys conducted by the RHA, they suggested that:

any apparent improvement in recruitment had resulted from artificially low demand, particularly in the case of unqualified staff, who had been most hard hit by cuts in establishments.

They were also unconvinced by calculations of nursing staff increases and suggested that greater workloads had been experienced.

However, as shortages were established and the significance of demographic change realised, Staff Side's tactics changed. In marked contrast to some of their earlier arguments, supply and demand factors were now asserted to have some importance. In 1986 they argued that demographic factors would make fair and appropriate pay levels even more important (p8) for qualified staff and that recruitment difficulties were likely to extend to posts for unqualified staff, many of which were filled by women returning to work after child rearing. Other employers would in future compete for this group to make up for the fall in the number of school leavers and, consequently, the pay and conditions available to them elsewhere would improve. Staff Side claimed the NHS was lagging behind other employers and felt that:

the best way to deal effectively with the situation was by a significant improvement in the pay and conditions of all nursing staff and in particular those on the lower scales (1990:4).

Staff Side also queried whether the HD's had adequately demonstrated that shortages were limited to London and the South East or to certain specialities elsewhere and provided their own regional breakdowns, compiled from newspapers, of wards closed and beds lost as a result of shortages of nursing staff. For example, in 1987, these indicated that there were shortages in all regions. Similarly, a survey carried

out in the same year by an Opposition health spokesman indicated 100 of the 120 responding health districts reporting difficulties in recruiting nursing staff, and RCN, RCM and HVA surveys confirmed such shortages. Staff Side also noted increases in numbers seeking verification of qualifications to work abroad (1988:9).

Staff Side have consistently pointed to low pay as a primary cause of shortages, and claimed that general pay increases are necessary to resolve them. They have been broadly in agreement with the idea that non-pay initiatives should also be developed but extremely sceptical about where the funding would come from as these type of initiatives are not without cost. Staff Side have sought meetings with Management to discuss how a number of proposals could be put into practice, and have tended to put forward their own agenda for non-pay and 'flexibility' initiatives. This has included increased childcare facilities, improved opportunities for part-time working, increased flexibility of hours, and retraining for returners (1989:5). The agenda has also been extended to include requests for the implementation of an equal opportunities policy, job sharing and improvements in maternity leave. However, they have pointed to the fact that surveys demonstrate that little has been done in practice in the area of non-pay related initiatives with fewer than 2,000 places in NHS workplace nurseries and only just over 200 job sharers in nursing posts in the NHS. With respect to non-pay initiatives involving training changes, Staff Side have argued that these would actually necessitate more staff, both qualified and unqualified, in the future:

to compensate for the changes in nurse education which would result in student nurses spending less time working on the wards during their training...The demand for more nursing staff would grow, simply in order to maintain the current level of service (1991:4).

In later years, Staff Side have expressed dissatisfaction with the results of the Clinical Grading exercise in terms of recruitment and retention and produced the RCN's Grade Expectations, a sample survey of RCN members, (IMS,1988) to conclude that the clinical grading

review at that date appeared to encourage nurses to remain in clinical nursing rather than to move to management or education or to stay in, or return to, the NHS. COHSE's surveys (various years), have also been used to show the serious number of potential leavers, with low morale, the level of pay and stress being most frequently given as reasons.

PRB'S Adjudication

The PRB's adjudications have developed alongside the arguments made by both Sides, especially with respect to the growing evidence on shortages, and by the fourth report the PRB suggested that the successful tackling of staff shortages would need more competitive pay (1987:14-15). In 1988, the PRB concluded that recruitment and retention difficulties were worse than previously believed, were not confined to London, and added up to a significant and widespread problem. Concern was expressed at the lack of statistical evidence from the HDs in support of their statement that there was no generalised recruitment and retention problem (1988:9). Most recently, a small improvement has occurred in vacancy rates but the PRB has explained that this improvement could have arisen:

'partly by the impact of the recession on the supply of nursing staff and partly as a result of NHS management apparently having taken vacant posts for qualified staff out of the funded establishment' (1992:7).

Throughout the period, the PRB has shown some ambivalence on the market forces concept and has produced some contradictory arguments. In several reports, the PRB noted that market forces were a relevant consideration at entry points into nursing (student and NAs) where staff need little formal training and can move freely across various occupations, but that they did not play such a role for qualified nurses where there is only a small effective market elsewhere. In this situation, they felt that:

The logic of the argument about market forces would...suggest that pay levels need be set only marginally above the point at which significant losses would occur from nurses abandoning their profession altogether and seeking other forms of employment. Those who commit themselves to a professional career such as

nursing, and eschew industrial action, may reasonably expect that wider considerations than this will be taken into account in settling their pay (1985:14).

However, later in the same report the PRB pointed to the importance of experience gained by nursing auxiliaries suggesting that this made them 'more significant contributors to the work of the nursing team, particularly in the difficult areas of mental illness and mental handicap' (1985:20). This argument would suggest that nursing auxiliaries also make a 'commitment' to the NHS and rather contradicts their earlier statement on the significance of market forces at these 'entry points'. In 1991, the PRB re-asserted the reservations they had expressed in 1985 on the extent to which 'evidence on recruitment and retention can be regarded as decisive' (1991:6).

The PRB has also acknowledged demographic factors suggesting that demand would outstrip supply in the future and particularly noted the Committee of Public Accounts' comments in its report on Control of Nursing Manpower, to the effect that the 'prospect of a future shortage of nurses, both qualified and in training, is a most serious matter of direct importance to the patients' (paragraph 22, Fourteenth Report, 3 February 1986). In recent years, the PRB has noted there is 'no cause for complacency' in the face of demographic facts and increasing competition in the labour market (1989:5).

Since the clinical grading exercise and a subsequent pilot for flexible pay, the PRB has been wary of statistics on recruitment and retention, noting that they bear a time lag in showing the effects of these special exercises and are therefore of 'limited value'. In 1991, it expressed concern about the deterioration in the position for Grades A and B but noted that there was still 'as yet no conclusive evidence about the effect on recruitment and retention of the clinical grading structure introduced in 1988' and that it would be difficult 'to identify or measure these effects with any precision, not least because they cannot be insulated from the many other developments currently taking place in the NHS' (1991:5). It again saw 'no cause

for alarm' but equally no 'reason for complacency' and pointed again to the need for competitive pay (1991:6)

Finally, although a pilot was introduced, the PRB has been sceptical about flexible pay supplements as a solution to shortages, appearing on the whole to be in favour of general pay increases. The concept of non-pay initiatives has been supported but the PRB has also noted variable response by individual HAS. Evidence on non-pay initiatives has been requested (1991:6) and the PRB has stressed that sufficient priority and identified resources are needed. It hoped that that some of NUPE's proposals, including those on childcare provision, would be put to negotiation. (1990:5).

Conclusions on Recruitment and Retention

The criterion of recruitment and retention has been a pivotal one in the pay review process and the growing evidence of shortages alongside the development of data collection adds some weight to some of the more descriptive historical accounts of shortages in Chapter Two. That this part of the process has taken up so much time and effort on all sides could be viewed in a number of ways. Firstly, it may simply reflect the traditional importance of this issue and the interests of both the Sides and the PRB in it. Secondly, it could be viewed as a mark of the success achieved through tactical agility and strong argument by Staff Side. Staff Side have produced a number of arguments and substantial evidence to counter HD's arguments and the PRB has in many ways appeared sympathetic to the Staff Side's views. Thirdly, it could be viewed as a mark of the success that can be achieved in setting the original agenda. Although government was forced to cede ground, the issue has drawn attention from some of the equally long-standing issues such as low pay and equal pay.

What is very clear, however, is that the approaches of the Sides illustrates many points of conflict even when the agenda is set so as to apparently address an 'objective' economic criterion as opposed to a more 'subjective' or equitable goal. The diversity of possible

measures of the extent and type of shortages, causal explanations and potential solutions leave scope for considerable differences of opinion and tactical strategies.

Perhaps most importantly, the criterion of recruitment and retention has subsumed the majority of economic and equitable arguments contained in other criteria in the pay review process, in both 'core' and 'ad hoc' categories. In particular, it illustrates what may be viewed as more genuine and fundamental conflict over the 'underlying issues' of grading and hierarchy, training and skills, employment and resourcing, and even notions of flexibility. Much of this conflict is expressed only indirectly through the pay review process and negotiation or decisions on many of these issues have taken place elsewhere. This puts the extent to which the PRB has been able to 'resolve' conflict over this criterion at some doubt.

MOTIVATION AND MORALE

Motivation, as the third of the government's core criteria, appears to be a strange choice from the point of view of both economic theory, where low motivation could be argued to feed through into lowered productivity or less willingness to supply labour, and from the point of view of tactics. The tactics may be more explicable given nurses' general reputation of being a very highly motivated group of workers as far as their patients are concerned. However, the PRB quickly established that a distinction should be made between motivation and morale in that staff might be 'totally committed to meeting the needs of patients and yet feel aggrieved to a greater or lesser extent with their pay and conditions' (1985:15). By the fifth report, these remarks were fully reflected in the redefinition of this criterion to considerations of morale.

A very rare deviation between the arguments of parties to the Management Side occurred over this issue but there was little consistency in their positions. In the first report, the HDs stated there was no evidence to suggest any excessive problems. However, by

the second report the RHA Chairmen thought a survey might be in order and the HDs acknowledged that attitude surveys could be of some use after general management changes had been fully operationalised. At this stage, the RHA Chairmen noted that they did not think competitive pay rates were the most important factor influencing motivation and morale. By the fifth report, the HDs had admitted morale was 'not good in substantial areas of the NHS' but that they had high hopes of the clinical grading review and improvements in communication and management. In the 6th report, the RHA Chairmen said in oral evidence that 'they did not believe that morale was fundamentally bad'. They suggested that a 'dissatisfied minority of staff had had a disproportionate influence'. However, the HDs said in oral evidence that they 'acknowledged that many nurses were currently anxious and unsettled' (1989:9) and that the proposals in Project 2000 and possible changes in management structure added to the uncertainties. In the 7th report, the HDs did not appear to pursue the issue of morale.

In the first report, and in direct contradiction to the HDs, Staff Side said they thought that morale was very low (1984:9) and this has remained their position throughout the period. They have backed up this position with their own surveys. In assessing the reasons for such low morale, Staff side have variously reported financial cutbacks, inadequate staffing and increased workloads, uncertainties resulting from NHS management or other reorganisation (PRB2,3,7,9), staging of awards, disappointment with pay increases, and the government's handling of the clinical regrading review 'which had reinforced the belief among staff that they were undervalued' (PRB6). With respect to solutions, Staff Side have recognised that pay is 'not the only influence on morale' but have argued that 'improvements in pay could help offset the effect of other influences' (1986:12).

From the outset, the PRB acknowledged that there were indications that morale was falling (PRB2). Clinical grading and poor management have consistently been seen as being important factors in low morale. For example, despite remaining optimistic about the positive effects of

clinical grading on morale in the long term, the PRB noted that:

in view of the number of appeals against grading decisions that remain to be heard, it is not surprising that there is as yet no evidence of any noticeable improvement. Our attention has been drawn...to variations in grading judgements by health authorities, not all of which are apparently explicable by reference to differing local circumstances...unless these anomalies are resolved quickly through the appeals machinery, they will leave a sense of unfairness which will inevitably have a detrimental effect on morale (1990:8).

Workloads have also been viewed as a problem and the PRB has commented that there is 'no reason to believe that they have diminished' or that the work of many nursing and midwifery staff 'has become less stressful' (1990:8). The PRB has also agreed with many of Staff Side's arguments on the sources of problems, particularly the NHS reforms and flexible pay supplements. The latter were seen to have 'given rise to feelings of resentment amongst some staff' (1990:8)

With respect to solutions, the PRB has been rather more ambiguous and contradictory. In the second report, it felt that the importance of pay 'must not be under-estimated' (PRB2,1986:16-17). In the fifth report, the PRB appear to have been much influenced by their visits and took the 'view that pay levels have a bearing on morale and that this relationship cannot be ignored' (1988:11-12). Later, the PRB stressed the role that improved management could play, but recognised that 'pay levels also have a significant effect on morale, not least because they indicate to staff the value that is placed on their work and responsibilities' (1990:9). Interestingly, given its more general views on low pay, the PRB here asserted that 'the NHS must not allow itself to become again a low-wage employer relative to its appropriate labour markets' (1989:9-10). However, there was a sea change in the 9th report, where the PRB argued that:

Pay was not a big issue: most of the points raised were really concerned with management rather than pay...many of the issues raised by staff...can be addressed more effectively by management action than by increases in pay (1992:8).

In conclusion, Staff Side have until very recently had some success in raising the profile of this criterion and in using it to bring wider

issues concerning the NHS funding and reorganisation into the forum of the PRB process. However, the pace of the reforms and managerial change may currently be obscuring underlying problems with pay. Staff Side have been substantially blocked in their attempts to link this criterion into the labour supply question, not least because under the Recruitment and Retention criterion a short-run emphasis on immediate supply and demand outcomes has prevailed, whereas motivation and morale has much more to say about the long-term expected impact on supply and demand. Although this criterion allowed an expression of Staff dissatisfaction with current change and equally enabled the PRB to express its sympathies, the criterion seems to have held little tactical advantage to government otherwise and the HDs and RHA Chairmen showed a rare lack of cohesion.

PRODUCTIVITY AND WORKLOAD

This criterion appeared to be a mainly neutral issue. However, it offers an interesting example of the government's failure to use the logic of economic arguments based on marginal productivity theory, where these are not tactically favourable. It also points to some potentially significant problems with the government's public commitment to link pay more directly to performance.

The Health Departments have offered contradictory evidence on productivity in terms of theory and evidence and, in particular, to whom gains should accrue. In general, the emphasis of their argument has been that there is no case for a general pay increase for staff on grounds of productivity. In the first report, the HDs stated that 'patient services must have first call on any efficiency gains' rather than nurses' pay. They also claimed that productivity in the NHS had not increased to any significant extent during the last decade, though the nature of jobs had changed as a result of advances in technology and medical knowledge (1984:11). They subsequently suggested that 'not all increases in productivity resulted from an increased level of skill or effort on the part of individual staff' and that there was no evidence of increased workloads (1985:11). Productivity was defined

as output compared with total staff numbers and considered to be less in the NHS than in the economy generally.

In the 3rd report the HDs shifted emphasis and pointed to a number of problems with measurement of productivity. In particular, they argued that there is a lack of evidence on the contribution by staff group, grade or service sector, and that the index of clinical activity takes no account of quality. Further, productivity growth was argued to be less than in the economy generally because the NHS, unlike the commercial sector, can not drop disproportionately costly activities (1986:11). In particular, the HDs saw 'considerable difficulties in relating pay to productivity where health care was provided by teams whose members had different qualifications and skills' (1986:11), and improvements in productivity might have been made by the substitution of qualified for unqualified staff which would already be reflected in higher earnings (1986:11).

The Staff Side in PRB1 pointed to the need for extensive discussions on the criteria to be used in measuring productivity (1984:11), and subsequently pointed out that measures of throughput were normally quantitative and said little about the quality or effectiveness of nursing (PRB2). Their view throughout the period has been that workload in the sense of demands on staff has increased in both quantitative and qualitative terms because of higher turnover, increased use of technology, and pressures on staff resulting from financial constraints. Surveys were again used to back up their case with evidence. COHSE's survey reported that 78% of respondents thought their workload had increased over the previous year (1986:11-12). The RCN presented findings from the IMS survey of 1987 which found that almost half of the respondents had worked unpaid overtime averaging 3 hours in the previous week, and had lost an average of 1.6 hours in the week by working through meal breaks, particularly nurses in the higher grades. The RCN contended that nursing staff needed to work overtime to maintain adequate levels of patient care, because workloads were increasing at a time of staff shortages.

Staff Side have remained resistant to performance pay 'in a service where teamwork was essential' but have felt that increasing workloads of staff generally should be reflected in their pay (PRB5). They have stressed that the root cause - inadequate staffing levels - should be addressed, but have noted that recruitment and retention difficulties may prevent this.

From the outset, the PRB has consistently judged that there have been productivity and workload increases and has reported evidence from the NHS itself, one such being that the 'main thrust of the 1984 Annual Report on the Health Service in England, published by DHSS, is that the NHS and its staff are continuing to improve their performance to the benefit of their patients' (1985:17). However, the PRB has equally consistently argued that measurement difficulties for productivity mean that it has not been able to take productivity into account (1986:16,1987). It expressed a desire to take it into account after the clinical grading review which it expected to help to retain staff in key areas and reduce stress caused by excessive workloads (1988:10-11). In the 7th report, workload was covered briefly under 'morale'. In the 8th, productivity did not appear.

Of all the criteria in the PRB process, productivity has probably had the most bizarre and confused treatment. Within the four criteria covered here, it was ostensibly attractive from a market forces theoretical perspective. Yet in so being, it was also the most attractive for Staff Side in a tactical sense. There is a particularly clear link between productivity and pay in such a labour-intensive sector and it would generally be regarded as politically inexpedient for government to claim that performance has in fact been poor in the public sector. Staff Side could thus be viewed as having achieved some success in assuming this criterion under their own agenda. However, it is interesting to note that the PRB has appeared unwilling to follow the logic of 'increased workloads', which provides a certain 'economistic' rationale for productivity pay increases, and has favoured sympathising with 'stress' levels. As with 'motivation

and morale' this offers a rather alternative view of this part of the review process and its possible effect on dampening conflict.

DIFFERENTIALS

Staff Side in the first report stated that there should be 'fair internal differentials, with staff being properly rewarded for their qualifications, responsibilities and experience' as one of their four key principles (1984:8). The meaning of 'fairness', however, might have been expected to be a major point of conflict, as could have the relationship between reward and qualifications, responsibilities and experience. Differentials normally refer to the differences in pay between groups of staff 'internal' to an organisation. In practice, the term has been used quite loosely within the PRB process and sometimes interchangeably with relativities. The practical linkages are so great between differentials, relativities and comparability that it is misleading for some purposes to try and view them as conceptually distinct. However, the concept of differentials allows the exploration of deeper considerations on 'internal' wage hierarchies and sources of conflict arising from 'underlying issues'.

Differentials were discussed in PRB1 under 'Pay Structure' and 'Pay Differentials'. Both Sides pointed to the need for certain changes in the pay structure to be negotiated, with especial regard to clinical grades to reward experience and responsibility and provide a career path. Staff Side were less cohesive on this criterion, as might have been expected. Although Staff Side in the first and second reports argued that unqualified staff merited higher pay on the basis of substantial responsibilities for patient care (see for example, 1985:12), separate submissions were made in these early reports by the RCN and professional associations. In the first report, the RCN proposed increases in differentials between student and qualified nurses (1984:10). When in the third report it was noted that the clinical grading review was to be undertaken, the HVA, RCM and RCN all put forward special proposals, whilst Staff Side - and the

Health Departments - generally were more cautious about making too many changes before the review was completed (1986:10-11)

The Health Departments have usually taken the position that pay increases geared to change differentials are not warranted. However, if any differentials are to be changed, the change should be in favour of qualified staff (1985:10). The HDs have expressed particular concern over any widening of the differential between nursing auxiliaries and ancillary staff, suggesting in the second report that 'any further widening would be undesirable and unjustifiable by reference to managerial or market considerations' (1985:12).

Despite the relatively modest amount of evidence under this criterion, the effects have been very important. In these early reports, prior to the clinical grading review, the PRB very much followed the example of earlier arbitration and review and increased differentials in favour of qualified staff. After the fourth report, no separate section appeared for the criterion of differentials, or 'internal relativities' as the PRB frequently called them, and the criterion was subsumed under the special sections in the reports on clinical grading.

The progress of this criterion again raises a number of questions about the nature of the review process, representation on the Sides and the role of the PRB itself. Relatively little pressure is visible through evidence for the recommendations which follow on differentials and this suggests that much wider, and less visible, external influences and sources of power are involved. One union official suggested that all the important representations take place 'behind closed doors' and that the professional associations have strong informal methods for applying pressure. At another level, the sociological composition of the PRB could be argued to bias it in 'conserative' directions. At a rather different level, it could be argued that the pay review system was set up to head off trade union pressure and increased differentials may be seen as the natural logic

of this system, whatever the causation behind the processes and recommendations.

One of the notable parts of this process has been the fact that the PRB did not consider that questions concerning pay structure fell within its remit (1984:10), despite the high degree of interlinkage between pay structures (or hierarchies), differentials and comparability, and this further illustrates its limits. The wider debate had, in fact, to be conducted outside the PRB in national negotiations, and then in the assimilation and appeals process at lower levels. Some of this process, however, is visible in the PRB reports through the debate on Clinical Grading where it is also possible to see the vital role that the PRB itself played.

SPECIAL DUTY PAYMENTS, LEADS AND ALLOWANCES

The core criteria addressed so far have been concerned with basic pay. However, pay supplements in the form of special duty payments and leads and London Weighting have also formed part of the PRB process. Substantial negotiations have taken place outside the pay review process over these issues and the role of the PRB has frequently been to urge the Sides to negotiate further.

Allowances designed to remunerate rather than reimburse fall into two categories; those expressed in terms of a percentage addition to basic pay and which therefore increase automatically in line with pay increases (special duty and excess hours payments) and those which are fixed sums (psychiatric and geriatric leads). The HDs and RHA Chairmen have generally argued that present levels of special duty payments are 'a disincentive to the flexible deployment of nursing staff', as are the psychiatric and geriatric leads which are 'divisive and complicated to administer' (1984:11). The RHA Chairmen in particular argued for abolition of both in the first report (ibid). Staff Side have generally remained unconvinced by the inflexibility arguments and particularly unconvinced that the abolition of such payments would be used to enhance basic pay (1986:22-23).

Negotiations between the Sides in the NMNC have taken place for most of the pay review body period, with the PRB meanwhile making interim recommendations, and the HDs have recently been attempting to negotiate the complete replacement of national leads and allowances with a comprehensive system of pay flexibility at local level (PRB9, 1992:15).

CLINICAL GRADING

Apart from the core criteria discussed above, two special exercises have been conducted during the period of the pay review body which have introduced different considerations and, although overlapping with other criteria, have generally been reviewed in the PRB process in their own right. The first of these was Clinical Grading.

In the fifth report, a special section was devoted to the Clinical Grading Review. The review took the form of a negotiated agreement on grading criteria (skills, responsibilities and qualifications) and grading definitions for nine distinct grades of post, which were designed to replace the previous gradings in the range from NA to senior nurse level seven and include clinical teachers and tutors. The PRB was then asked by the Negotiating Council to recommend rates of pay for the new grades, in the form of a pay spine to be backdated to 1 April 1988 once the new structure had been introduced. Assimilation was to be on the basis that staff would move to the incremental point on the new scale corresponding to the incremental point reached on the old scale.

The Health Departments stressed that the new career structure would recognise the various levels of skills and responsibility exercised by 'individual' nursing staff and would establish appropriate relativities between different jobs and aid recruitment and retention. Differences of opinion arose very quickly on the nature of the exercise and on the role of skills, experience and responsibility. Whilst HDs wanted wider overlaps in scales to 'reflect the value of skill and experience gained over a period of years in the same grade',

Staff Side wanted minimal overlap, arguing that the whole purpose of the exercise and the new structure was to reward different levels of skill and responsibility and that this should be reflected in the grading itself rather than through increments alone.

The PRB in the fifth report was prescient in its anticipation of problems arising from the assimilation of staff to the new grades. It noted that 'if the new structure is to meet the needs of nursing and midwifery staff over the next decade, it is important that it should clearly be seen to value the work done by these staff and should gain their confidence from the outset' (1988:17). The PRB's own objectives included minimal overlap and 'consistent and reasonable' differentials between successive scale maxima. The PRB pointed out that 'it is for the management of the NHS to ensure implementation of the new structure...with urgency...a prolonged period of uncertainty will inevitably distract staff and cannot help to build up their morale'. It also pointed to the dangers if the HDs did not give sufficient and timely guidance for implementation, in particular that 'it would be difficult for local managers to insulate their judgements about grading from their preoccupation with budgetary constraints' (1988:18). Finally the PRB feared that the prospect of improving the attractions of a nursing career would be 'put at risk if it is accompanied by increasing pressure on the resources available for patient care or for the provision of post-basic training'.

In the event, a number of problems arose from the outset. The Sides failed to agree the interpretation of the grading criteria and therefore the point-to-point method of assimilation (1989:1). The PRB also noted that the HDs were unable to issue any comprehensive guidance to health authorities on regrading and assimilation until May, 'nearly six months after the grading definitions had been agreed by the Sides'. The PRB's visits had confirmed its belief that local managers were inadequately prepared for the exercise (ibid).

Data on regrading outcomes were extremely poor and Staff Side felt that management had frequently behaved insensitively and

inconsistently, with many anomalies arising in assimilation, not least because of the 'cash limited' nature of the exercise which had led to the 'imposition of quotas of staff to be assimilated to each grade. They suggested that many NAs and ENs had been placed 'automatically in the lowest grades for which they were eligible, without any attempt having been made to assess the work they were doing'. Particular problems had arisen over 'continuing responsibility'. Here, the HDs had ruled that continuing responsibility for a ward could not be shared and that only one post in a ward could be graded G. Problems also arose over the notion of 'prime care provider' and the grading of midwives, some of whom were placed in grade D and over whose assimilation many anomalies and inconsistencies arose regionally (see especially 1990:10-12). This threatened a split in Staff Side as the RCM called for a separate grading and salary structure for midwives, though Staff Side achieved some success in rallying to the midwives' cause collectively.

Most of these points have arisen each year since the review. The PRB has generally made it clear that it was for the 'Sides to deal with the problems through negotiation' (1989:6), yet again emphasising the limitations of the pay review process and the potential importance of negotiation and consultation at national and, for this exercise, local level. However, the PRB has been a vocal critic of the exercise throughout and has frequently appeared sympathetic to Staff Side but unable to act. For example, in the seventh report, the PRB noted 'with regret' that 'there are still differences of opinion between the Sides about certain of the grading criteria and that this appears to have caused particular difficulty and distress in midwifery' but also that 'it would not be right for us to intervene', claiming that responsibility for the implementation of the grading structure must rest with NHS management (1990:12). It has shown particular concern for anomalies arising over the assimilation of midwives, feeling there were 'financial implications' over and above issues of 'equity' which suggested the inconsistent grading in different areas was a result of poor management.

The clinical grading process has also allowed Staff Side a very public airing of grievances. They have been consistently concerned about the effects on NAs and ENs. In particular, Staff Side have been concerned about the low pay and lower grading of staff working part-time and night duty. They have claimed, with respect to appeals arising from the review, that the major anomalies which remained were those introduced by the HD's guidance on the interpretation of the terms 'supervision', 'continuing responsibility' and 'prime care provider'. They have further claimed that it was 'the refusal by Management Side to discuss these issues' which had led to an unprecedented number of appeals which had high financial costs and lowered morale (1991:12).

The most surprising outcome of the clinical grading review and its coverage in the PRB process, in the context of the historical divisions in nursing discussed in Chapter Two, has been the degree of unity achieved by Staff Side in appealing for lower paid staff to receive more. They have made such appeals consistently since the grading review and have even said in oral evidence that their concern for staff in the lower grades had led them to put forward these proposals, 'even though the effect of them would be to narrow differentials and to increase the extent to which scales overlapped' (1990:10). Even if a 'ratcheting' strategy could be perceived, this would still represent a very cohesive approach. Their arguments could be interpreted as having persuaded the PRB in several years to change differentials in favour of lower grades. However, the PRB may equally have been influenced by the growing evidence of shortages of unqualified staff in these later years (see 1991:13 in particular).

Despite criticisms from the PRB, the HDs have maintained an impassive air, but part of their strategy has become visible through their comments. The HDs have argued throughout that the new clinical grading structure should assist health authorities to recruit and retain staff but that 'it would be some time before its full impact would be reflected in the manpower figures' (1990:11). The review appears to have been used partly as a 'stalling operation' against more general pay increases.

The HDs have argued, as under the 'differentials' criterion more generally, that the PRB should not change differentials. They have also maintained that some regional recruitment and retention problems, notably in London and the South East, would be best dealt with by flexible pay as the labour market for unqualified staff was very 'local'. With regard to Staff Side's suggestions for increases for grades A and B (NAs), the HDs have stated that:

any significant alteration could cause problems later as the role of the health care assistant evolved with the introduction of national vocational qualifications for occupations in the care sector (1992:12)

and later suggested that the introduction of national vocational qualifications and of a more general flexible pay system 'should have a beneficial effect [on motivation] for staff in the lower grades' (ibid). On the grading of midwives, the HDs have argued that their guidance was 'not a distortion of the Sides' agreement' and that 'midwives had gained more from the clinical grading structure than had nursing staff generally'. With respect to regional variations in such grading, the HDs have asserted that grading depended on such factors as 'local management arrangements, the geographical layout of services, and deployment and skillmix'. Although the majority of midwives are trained as nurses and then receive extra training, the HDs argued that:

it was not inappropriate to say that only one registerable qualification was needed to practise as a midwife, especially as the RCM supported direct entry training courses...although until recently only eight people a year had been able to qualify in this way, a second direct entry course was now available (ibid).

The PRB has frequently appeared to concur with the HD's view that clinical grading must be given time to work in its recommendations. For example, even in 1992, it argued that, until the appeals have finally been settled, 'we will not be in a position to evaluate nursing and midwifery staff's pay levels and relativities as thoroughly as we would wish' (1992:12). The promised wider exercise in comparability has thus been held up substantially.

Clinical grading in some respects stifled the previous orderly presentation of arguments, and raises substantial questions about the interlinkages between, pay and 'non-pay' issues. The promise of clinical grading appeared to act as a 'holding' mechanism, particularly with respect to a wider overhaul of comparability measures or of the normative criteria which should be applied to determining nurses' pay. The exercise also acted as a form of 'review within a review', ostensibly resembling the traditional forms of pay review such as Halsbury and Clegg, in that it occurred on an electoral cusp and offered the means for a 'catch up' award. Outcomes following the clinical grading exercise reflected not only PRB awards, but also prior negotiation, and external pressures and funding constraints. The latter were reflected in the grades in which nurses were initially placed and their subsequent appeals. The HDs appeared, from the evidence in process, to attempt to use the clinical grading exercise to keep down the pay of lower grades in readiness for grademix changes, and more generally to decentralise pay through devolved decisions on grading. The role of the PRB thus became somewhat indeterminate along with its role in the 'resolution' of conflict.

LONDON AND SELECTIVE PAY SUPPLEMENTS

Further impetus is given to the above conclusions by the process around the second 'ad hoc' criterion, flexible pay supplements. From the fifth report onwards, there have been incremental attempts on the part of HDs to introduce so-called 'flexible pay'. This concept was first raised when the HDs argued for geographical payments and the RHA for London and selective (flexible) pay supplements. The PRB was initially sympathetic. Despite its view that shortages were widespread, it also acknowledged that there were significant geographical and functional shortages (1988:22). As with clinical grading, however, the PRB has had a rather ambiguous role, both as facilitator and critic.

The HDs initially proposed extra points on the pay scales, in addition to London weighting. Staff Side immediately expressed their opposition

to pay variations on a regional or any other basis, stressing their view that national pay rates were 'important in the promotion of teamwork and the maintenance of a unified and professional workforce' and that 'morale would be eroded' (1988:22). They argued that the solution to the London problem, the existence of which they acknowledged, was to increase London Weighting. They also opposed any discretionary pay. The PRB took the view that London Weighting was a matter for negotiation in the General Whitley Council, that it did not come within its remit, and that in any case the London problem should be dealt with wholly in one forum, either Whitley or the pay review process. However, and despite these reservations, it went on to recommend supplements (rather than additions), on a percentage basis, to the pay-spine, claiming that these could better be monitored, and that the supplements would remain 'subject to review'. The percentage supplements were later criticised by Staff Side as 'anomalous', leading to lower paid staff being 'doubly disadvantaged' (1989:16-17), but defended by the HDs because 'the recruitment and retention position did not justify a higher percentage for unqualified staff' (1990:20). The HDs in the fifth review withdrew their proposal for 'discretionary' supplements, feeling this would be 'premature' and should be discussed with Staff Side (1988:23-24).

In subsequent years the step-by-step approach followed by the HDs and RHA has become clearer. The RHA claimed in the sixth report that the London supplements had been 'welcomed...as a first step towards a more flexible pay system' (1989:16-17), and flexible supplements were introduced in this year. By the seventh report, the issue of London supplements was made distinct from that of flexible supplements but de facto overlaps remained. Staff Side agreed to leave the London Weighting Consortium of the General Whitley Council and join the HDs in inviting the PRB to recommend appropriate rates. The HDs then said that the new arrangements for determining pay in London:

were an important step towards their objective of having the whole question of London pay treated as a single entity to enable resources to be directed at specific problem areas, without regard to artificial geographical boundaries...it would be appropriate to begin to move away from across the board flat rate allowances in London and to replace them with more flexible

payments targeted to grades, specialities or locations where there were particular recruitment and retention difficulties (1990:20).

They therefore proposed the extension to London of the pilot scheme of flexible pay supplements.

The PRB subsequently recommended an extension of flexible pay supplements to London, again despite noting strong reservations:

the extension to London of what is at this stage no more than an experimental scheme should not be regarded as a substitute for improved remuneration for all staff in London...through basic pay plus whatever adjustments may be necessary to meet the circumstances of staff working in London insofar as they differ from those of staff working elsewhere [London allowance - weighting + London pay supplements] (1990:21).

Selective, or 'flexible', pay supplements were thus introduced the year after London supplements (PRB6) and, as can be seen above, soon overlapped substantially with London supplements. These supplements were apparently intended to be both geographical and by speciality, but there has been a great deal of confusion over these separate objectives. Functional variations, for example, are in some ways more important as they change differentials and relativities within geographic areas. The HDs said in PRB6 that they were anxious:

to introduce more flexible remuneration arrangements which would enable pay levels to reflect differences in labour markets...and to see greater scope for geographical variation in pay...the aims of the scheme would be to help meet a small number of particularly difficult cases of recruitment and retention and to pilot criteria for selective pay supplements with a view to developing them for more general use (1989:20-22).

This view developed further the following year, when HDs, noting that a flexible pay system had been negotiated for administrative and clerical staff, said their objective was:

to introduce comprehensive and systematic flexible pay arrangements within the NHS which would include a substantial element of local management discretion within a framework of minimum essential central control...[it was their intention]...to negotiate a fully developed scheme of flexible pay for nursing and midwifery staff with the Staff Side...such negotiations would include future arrangements for London pay and the psychiatric and geriatric leads (1990:17).

The Minister for Health made an extremely rare appearance in the PRB process to argue, in oral evidence, that 'a general pay increase to resolve staffing problems would be too costly' and that it would be 'more efficient and effective to target increases to particular areas by means of flexible pay initiatives' (ibid).

Staff Side have argued, however, that pay variations would not solve recruitment and retention problems: at best they would 'simply shift shortages around the country and between specialities', and 'at worst they would make the retention of staff more difficult by causing resentment and by damaging co-operation' (1989:20-22). In their view, the proper implementation of clinical grading and adequate pay levels were better ways of addressing problems. They argued that they were not 'totally opposed' to the principle of local variations in pay but had strong reservations. Therefore any pay flexibility scheme should be discussed in advance between the Sides and should make provision for appeal by individual nurses or their representatives.

The PRB again played an ambiguous role. Against this background of lack of negotiation or consultation and fundamental disagreement, the PRB nonetheless said it was 'favourably disposed' to a pilot scheme as 'what constituted competitive pay in one part of the country might not be competitive in another' and it 'had already acted on this principle by recommending London supplements last year'. The PRB therefore recommended the pilot scheme and £5 million for it. However, it also expressed its own reservations and conditions. It agreed with Staff Side that non-pay initiatives should have been tried first and pointed to the dangers of uncontrolled pay drift if good planning of the system were not made, noting that 'selective pay supplements should not be allowed to become a soft option for poor management'. The PRB wanted good systems of monitoring and control and noted its sympathy with Staff Side's concern that the use of supplements would merely shift shortages. It further felt that the system should not be used to 'redress any deficiencies in the application of the grading criteria' and recommended that the Staff Side 'be brought into the

relevant discussions, both on the proposed implementation of the pilot scheme and on the conclusions to be drawn from it' (1989:20-22).

Flexible pay supplements continued and were extended by the PRB in 1990 (£12 million), but subsequent extensions have awaited negotiation on a wider system of flexible pay. However, pay supplements have received some very strong criticism in subsequent years. In PRB7, the PRB showed great concern about their effect on morale. Staff Side also reported that Management Side had failed to comply with the PRB's conditions and safeguards and that they had not been involved in the setting up, monitoring or evaluation of the scheme. The PRB acknowledged these grievances with some sharp reprimands to Management Side. In particular, it felt such supplements were:

not an adequate means of dealing with operational requirements nationwide...[and] should not be regarded as a substitute for an improved level of pay in London or of the psychiatric lead...offering higher rates of pay to small, carefully targeted, groups of staff inevitably carries the risk of arousing resentment amongst other staff...We believe that we are nearing the limit of the money that can be put into the pilot scheme...in the meantime we have not yet formed any final view of the desirability of introducing a general system of flexible pay nationwide (1990:18-19).

These criticisms were repeated the next year, and the ninth report then shifted to considerations of pay flexibility and performance related pay more widely. In 1992, the HDs were asserting that:

it was the Government's objective for the health service as a whole to introduce greater flexibility, in order to allow local managers to relate pay rates to local labour market conditions, to reward individual performance and to devise flexible employment packages which were most suitable to local needs...[they] would not be looking to fund pay flexibility outside, or in addition to, any general increases the Review Body might recommend for nursing staff (1992:4)

By way of example, the Minister for Health suggested in oral evidence that the PRB might in future consider recommending a minimum percentage increase, together with a target average, so leaving a margin to enable management to take both local labour markets and performance into account (1992:4).

The HDs in November 1991 sent the Review Body an outline of the proposals they intended putting to the Staff Side for the introduction of a general scheme of pay flexibility. Here they proposed that in future the PRB would be invited to recommend a 'target average percentage pay increase (TAPPI)' for nursing staff, of which a proportion would be recommended as a basic increase payable automatically to all staff (this could vary between different groups of staff) and the balance would be available for local flexibility, including performance pay. The PRB would also be asked in future to recommend freezing the existing leads and allowances in order to provide a further sum of money for use flexibly. Health authorities' funding would be based on the TAPPI and local negotiations would determine how the flexible part of it would be used. Local management would be empowered to negotiate agreements to buy out, or to adjust, the national leads and allowances, and to change annual leave and possibly other elements of non-pay remuneration. Financial control would be maintained by requiring HAs to ensure that the overall net effect of all the changes was an average pay increase for nursing staff in each of their units in line with the TAPPI figure (ibid). They added that an adequate proportion of the flexible element would be needed to reward performance on an individual or group basis.

Importantly, the PRB has suggested that the issues of pay flexibility and performance pay are conceptually distinct and should be dealt with as separate issues although the HDs' proposals do not distinguish between them. The PRB has said it is favourable to 'value for money' solutions but mentioned a number of potential problems with the proposals. The issue as at 1992 awaits the outcomes of the Side's negotiations as far as the PRB is concerned but may yet be overtaken by developments in the Trusts, or the scale of the crisis in public sector borrowing. Nonetheless, the process on flexible pay illustrates a curious propensity of the PRB - to be both facilitator and critic of the undermining of its own influence in nursing pay determination.

CONCLUSIONS

The structure and processes of the N&M PRB in many ways pose the same problems of interpretation as those raised by structure and process in prior forms of arbitration and review. The structure of the PRB itself could be viewed as antipathetic to the idea of 'independent' review, with members appointed directly by government and remaining unaccountable to those whose interests they are intended to represent. Most PRB members, albeit with arguable effect, also have very different class characteristics from the nurses whose pay is to be determined and of the majority of 'taxpayers' who represent the other main 'official interest' in the wage settlements. Whether the PRB as an institution or collection of individuals thus has interests of its own could only be inferred from process and outcomes but its 'independence' could be viewed as potentially circumscribed.

The production of evidence may have had some interesting, and unexpected, effects in its own right. It has certainly been very time consuming and one interviewee suggested that the associated clinical grading exercise may have distracted Staff Side attention and resources from wider reforms taking place in the NHS. On the other hand, it has helped clarify some arguments and strategies and there is some evidence that Staff Side have been able to present a publicly united front over most issues, and notably the issue of low pay in later years. The need for evidence has also highlighted perennial data deficiencies in the NHS and a RCN official commented that some of these have now been rectified although 'there is a long way to go'. This may have been an unintended consequence of the process along with the intense media interest generated by the reports and the fact that a public forum has now been provided through the formalised presentation of such evidence in published reports. However, it remains a moot point whether evidence has generated as much 'engagement' on the part of members as was claimed by some trade union officials, particularly when compared with the alternative of national or local collective bargaining.

Government appear to have had a degree of success in 'skewing the agenda' towards 'economic' criteria but the PRB has not accepted their argument that 'ability to pay' should form the main basis for recommendations. It is certainly questionable whether this was ever the government's realistic intention and it is hard to imagine how the process could have proceeded or been perceived as acceptable without any discussion of comparability. The diversity and significance of the comparability arguments put forward and their linkage to economic criteria contrast with much of the academic treatment which counterposes 'economic' and 'equitable' arguments. The exercise in applied orthodox economics that the process includes lends some credence to the view that these arguments carry little force for the public sector - and even less for nurses. Staff Side remain very unconvinced by these arguments and have become increasingly sophisticated in their refutations. The PRB has frequently had to counter the more radical neoclassical views, and Management Side has often offered contradictory evidence or had to make tactical shifts when the contradiction has become apparent in the 'rational' discussion.

The polarisation of criteria and arguments suggest that, tactical play apart, there are many points of material conflict between the Sides and this is particularly underscored by the underlying 'non-pay' issues which have surfaced throughout the process and had to be dealt with through other forms of decision-taking or negotiation. This was particularly in evidence over the clinical grading exercise which suggested both that conflict may have been driven to lower levels and that the pay review process had been, at least in part, contingent upon the continuation of collective bargaining over non-pay issues. The polarisation may also suggest that a number of interests which deserve or need to be represented might be excluded from the process.

More generally, for all the vast effort and expense in collection and presentation of evidence that the process represents, the effects remain ambiguous. This is not least because the PRB has maintained throughout that there is 'no mechanistic formula' to be followed in

pay determination. The PRB has maintained a largely sympathetic manner to nurses whilst broadly favouring arguments based on fairly orthodox economic criteria, which have tended to centre on recruitment and retention. The issues of low pay and equal pay have thus received short shrift, despite their high significance in the history of nursing pay determination and outcomes and Staff Side's equally traditional argument that the failure to address these links directly into nurse shortages. In countering the rationality of 'economic' arguments and working to the government's agenda, it could be argued that Staff Side have lost the moral force of their own agenda. An important development in process has been in the 'ad hoc' issues and the trends towards decentralisation, inherent in both clinical grading and flexible pay supplements. It could be argued that the PRB has played an ambiguous role in both facilitating and criticising these moves. However, the ensuing debate has raised a number of potential problems with the 'strategy' of decentralisation.

In summary, the role of the PRB in tempering conflict and in 'balancing' the power of the Sides can be seen to be open to debate. Inasmuch as a forum has been provided and the PRB is seen to 'sympathise' with a number of the Staff Side's arguments, the PRB system may have channelled conflict to some extent. The pay process is still, however, dependent on negotiations and decisions taking place elsewhere and conflict may be driven down to lower levels especially over 'underlying' issues. The cumulative effect of these issues, and conflict over their resolution, has been to undermine the scope of the PRB's remit. The wider reform of the NHS and the introduction of NHS Trusts threatens to exacerbate this effect by removing substantial numbers of staff from the direct coverage of the PRB and reducing the force of national pay determination. Interpreting the wider role of the PRB process and the desirability of pay review, requires an evaluation of material outcomes.

CHAPTER FIVE

EVALUATING THE PAY REVIEW PROCESS

This chapter focuses on the material effects of the pay review process in terms of pay outcomes and wage determination more generally. There are significant methodological issues and problems involved in any evaluation of wage determination and these apply with particular force to the case of nurses and the PRB. Chapters Three, Four and Five have been organised around an analytical separation of context, process and outcomes. The aim of this separation, namely to provide a more detailed analysis than would be found in an historical narrative, nonetheless introduces its own problems. It should be apparent that context, process and outcomes are not independent of each other either temporally or analytically. As an example of the temporal effect, a single year's PRB would be influenced both by the historical and current context, and experience gleaned from previous review processes and historical outcomes. That year's PRB process will then influence subsequent years. A flavour of this has been given in the last chapter.

Equally, context, process and outcomes could be regarded as a single and continuous flow, particularly if the emphasis is shifted from macro outcomes to more local outcomes to take resource squeeze and employment effects into account. As Beaumont has noted 'the performance of public sector industrial relations tends to be overwhelmingly seen in terms of wage outcomes' (1992:141). However, wages may more appropriately be thought of as a significant, but not the only important, aspect of the employment relationship. The last chapter illustrated how non-pay issues, such as employment levels and work intensity, grading, training and wider resource considerations, enter into wage determination and are, in turn, affected by wage outcomes. Many of these issues are also dealt with at lower levels of aggregation.

However, the macro approach chosen for this chapter offers certain advantages in analytical scope and in the detail allowed. The analysis is then deepened in subsequent chapters to explore non-pay and local interlinkages.

EVALUATING PAY OUTCOMES

This section explores the ways in which pay outcomes might be evaluated and the methodological and data problems raised by such an exercise. The primary methodological issue pertains to what is to be measured, how it is to be measured and with what it can be compared. The disputed nature of all these points has been seen in the process of the PRB and is exacerbated by lack of normative guidelines. Moreover, any evaluation of the outcomes of the PRB must proceed in a vacuum of knowledge of what would have happened in the absence of a review body. Although some indications of historical trends in nurses' pay were given in Chapter 2, extrapolation of such trends as a point of comparison would be of only limited value. Further problems relate to the increasing indeterminacy of the pay review process itself with respect to outcomes, a point which is discussed throughout this chapter.

These methodological problems are compounded by data deficiencies. With the exception of aggregate paybill totals and payscales, no information is published by the Health Departments on the actual remuneration of nursing personnel. The other main source of data on nurses' pay is the annual survey of earnings and hours conducted by the Department of Employment; the New Earnings Survey (NES). It will be seen that both these data sources are problematic.

The first part of this section reviews the evidence that can be gleaned from the paybill and pay scale measures and the problematic nature of this highly aggregated data. The second part of the section focuses on the use of comparisons. A wide range of comparator measures is reviewed including cost-of-living, average earnings, public and private sector earnings, career structures and other occupations, and

low pay indices. The varying levels of aggregation and use of movements or levels in comparisons are evaluated for their strengths and weaknesses, and specific problems with NES data are also examined.

PAYBILL AND PAY SCALE MEASURES

The aggregate wages bill and pay scales are measures which are frequently employed by the media and by academics in reviewing nurses' pay. Following its deliberations, the PRB issues its recommendations for consideration by the Prime Minister. These recommendations comprise a listing of current and recommended salary scales, leads and allowances and supplements. The PRB then estimates the increase in the total paybill which would result from implementation of its recommendations. These aspects of the PRB's recommendations tend to be picked up by the media as 'headline' pay outcomes, and the paybill increase is generally emphasised. For this reason, the paybill increase is the most public and visible outcome of the PRB process. However, it has increasingly become a deeply flawed measure.

Even in the early years of the PRB, this measure could be regarded as an inadequate indicator of labour cost. It is firstly dependent on the accurate provision of detailed manpower figures from the HDs. For example, such figures in 1991 were still only provided for March 1990 - in other words, outdated by a year. Secondly, it is also dependent on the difference between actual and forecast turnouts for employment level and mix over the year to which recommendations apply. In recent years the measure has become even less determinate, both as a measure of labour cost and as a measure of pay outcomes for individual nurses. The clinical grading exercise in particular has introduced additional elements of uncertainty. For example, the PRB noted in its fifth report that:

The increases which individual clinical staff receive will depend on the grades in which they are placed, and on whether they work in the London area. The increases will vary considerably. Our estimate of the increase in the total paybill, which would result from implementation of our recommendations, should not therefore be regarded as giving any indication of the increases individuals will get...Since assimilation of staff to the new clinical scales

depends upon local decisions based on a process of examining individual posts, it is impossible to predict with any certainty the numbers who will be receiving each level of pay (1988:29).

Appeal results, any changes in which must be backdated to 1988, have exacerbated this effect in every year following the exercise, as has the introduction of flexible pay supplements, the cost of which has not usually been included in the aggregate percentage figure. Moreover, the cost of students undertaking Project 2000 courses, senior nursing grades (now dealt with separately), employer's national insurance and superannuation costs and agency staff are also usually excluded. The last two cost categories were estimated for the first time in the Ninth Report along with an estimate for flexible pay supplements (1992:24), but this then rendered the Ninth Report paybill incompatible with previous paybill estimates. The wider reforms have meant the complete exclusion of health care assistants (HCAs) from the PRB's remit, and staff in NHS Hospital Trusts may also potentially be excluded, though the PRB currently estimates the wages bill with Trusts in mind. These changes obviously increase the problems of measurement.

The second main problem with the aggregate paybill measure concerns the government's implementation and funding of recommendations and a distinction must be clearly made here between the effects of such decisions on implementation and on funding. Staging or delaying awards produces a net saving for the NHS and a net 'cost' for nurses in that they simply do not receive the full value of the award recommended by the Pay Review Body in the year to which the recommendation pertains. In this respect, the PRB can no longer consider the effect its award would have had on such issues as morale or recruitment and retention. However, the practice of not fully funding nursing pay awards above a previously set allowance or of requiring part of the additional funding to be met by cost improvements programmes (CIPs) or income generation schemes (IGSs) has had a far more insidious effect, which is explored in the next chapter.

TABLE 5.1 PRB PAY RECOMMENDATIONS, GOVERNMENT IMPLEMENTATION
AND ACTUAL COST

1 Year	2 Estimated paybill increase %	3 Distribution (**)	4 Full/ Staged	5 Estimated actual cost %
1984/5	7.0	6.0 - 8.0 (q)	full	7.5
1985/6	8.6	4.0 - 14.7 (q)	staged	5.6
1986/7	7.8	7.0 - 9.5 (e)	delayed	5.7
1987/8	9.5	6.0 - 12.7 (q)	full	9.5
1988/9	15.3	5.1 - 45.3 (*)	staged	15.3 (*)
1989/90	6.8	6.7 - 6.9 (e)	full	6.8
1990/1	9.6	9.0 - 13.4 (u)	staged	8.0
1991/2	9.7	9.5 - 11.0 (u)	staged	8.4

Notes:

(*) the 1988/9 pay award included an interim increase of 4% paid in April 1988, and substantially higher, and variable, increases paid later (back-dated to April 1988) following the introduction of the new grading structure. The actual increase in paybill costs was substantially higher than 15.3% because of unpredictable grading decisions. In subsequent years, changes in grade distribution also result in an under-estimation of actual costs. The final column offers, therefore, only an indication of the anticipated impact of staging or delaying awards.

(**) in the column summarising the distribution of pay awards:
(q) = higher increases for qualified staff;
(u) = higher increases for lower grades and unqualified staff;
(e) = a relatively even distribution of pay increases.

SOURCES: Thornley & Winchester, ILO (1991/3) from IDS/Hay Group,
Pay in the Public Sector (1991) and Review Body Reports

Table 5.1 summarises the PRB recommendations on nursing staff pay and government response, and gives some estimates of cost saving made by the government through its decisions on implementation. This is mainly an aggregate analysis, although some indication is given in column 3 of alterations to differentials. It can clearly be seen from the table that, given its prior decisions on what can be afforded through its expenditure plans, cash limits, and other financial and administrative controls on health authorities, the government has

usually attempted to reduce the paybill cost of implementing the recommendations of the PRB.

In five of the eight years covered in Table 5.1, the government has either delayed the implementation of the recommendation by several months (as in 1986/7) or, as it has done on four occasions, implemented the award in two stages, with the second stage paid up to nine months later. The 9th report recommendations were also staged by the government. The delay in paying all or part of the recommended award has predictably disappointed Staff Side but has also been criticised by the PRB itself. In its third report, for example, the PRB commented that:

the Government's decision has delayed a satisfactory outcome for the pay of nursing staff, midwives and health visitors and has meant that the evidence available to us this year has provided no basis for assessing the impact of last year's recommendations on recruitment, retention and morale (1986:1).

When implementing the PRB recommendations the government estimates the anticipated increase in paybill costs, often reaching different conclusions from other parties' estimates. This then affects its further decisions on whether to make additional funds available over the allocation already made, in order to meet these costs in full, or in part. As noted on some occasions the government has specified which proportion of the additional paybill cost should be met by HAs through 'efficiency savings' or Cost-Improvement Programmes.

For this reason the recommended paybill increase - despite high visibility and the publicity of media headlines - is an increasingly inaccurate measure of pay outcomes. Although PRB recommendations have generally been higher than the Government's pay assumptions, which are usually based on lower allowances for inflation than calculations made by other parties to the process, implementation and funding decisions mean that government can then rein back on expenditure.

A good example of media emphasis on the above measure, and the less aggregate measure of wage scales, is provided by The Guardian's

coverage of the (1991) PRB outcomes (1.2.1991). Here it was reported that the government accepted the main recommendations of the eighth report of the PRB in February 1991, and that pay rises of between 9.5% and 11% added to the scales were to be implemented in two stages (April and December 1991), with slightly higher percentage increases for the lower grades. The revised pay scales were shown in the figures reported in the manner of Table 5.2.

TABLE 5.2 PAY SCALES OF NURSES AND MIDWIVES

Grade	Current Salary £s	April 1991 £s	December 1991 £s	Increase %
Student	5800 - 6750	6325-7315	6440 - 7450	10.4 - 11.0
Grade A	5950 - 7355	6485-7955	6605 - 8100	10.1 - 11.0
Grade B	7115 - 8115	7705-8770	7845 - 8930	10.0 - 10.3
Grade C	8115 - 9650	8770-10375	8930 - 10570	9.5 - 10.0
Grade D	9335 - 10700	10045-11505	10230 - 11720	9.5 - 9.6
Grade E	10700 - 12390	11505-12320	11720 - 13570	9.5
Grade F	11865 - 14545	12755-15635	12995 - 15920	9.5
Grade G	13995 - 16195	15045-17410	15320 - 17735	9.5
Grade H	15645 - 17860	16820-19200	17130 - 19565	9.5
Grade I	17305 - 19600	18605-21070	18955 - 21470	9.5

SOURCE: The Guardian (1 February 1991).

This method of presentation emphasises the trend in proposed increases rather than the cash increases actually received by nurses over the year and. As such it neglects the effect of staging and overstates the cash increase in a given year. However, this qualification apart, wages scales are possibly the least disputed measure of pay outcomes on their own terms and do provide some indication of the basic pay structure and any immediate changes in internal differentials. Nonetheless, the scales exclude additions to basic pay and non-pay benefits.

Additions to basic pay include unsocial hours and special duty payments, arising from the need to provide a 24-hour, seven day a week health service, and excess hours, or overtime payments, made where extra off-duty time cannot be granted. Additional payments are also

made to nurses working in care of the elderly, mental illness and handicap, and nurses employed in London. As was seen in Chapter Four, following negotiations between the Sides in the NMC, The PRB recommends changes in the value of leads and allowances.

TABLE 5.3 BREAKDOWN OF ESTIMATED 1991/92 PAYBILL, GREAT BRITAIN

	Cost £m	% paybill
Basic Pay	5,601	84.9
Special Duty Payments	644	9.7
Overtime	67	1.0
London allowance	129	1.9
Geriatric lead	10	0.2
Psychiatric lead	50	0.8
Secure unit allowance	2	0.03
On-call allowance	6	0.1
Standby allowance	1	0.02
Redundancy & maternity pay	38	0.6
Other non-pay related	9	0.1
Flexible pay pilot scheme	11	0.2

SOURCE: Adapted from PRB, 1992:24, Appendix D.

As can be seen in Table 5.3, allowances and benefits comprise just over 15% of the total nursing paybill. This aggregate figure has increased only marginally over recent years, and the relative importance of overtime has declined within the overall figure. However, allowances are a very important part of the remuneration package for groups of lower paid staff in some areas of nursing; for example, unpublished figures supplied by the Department of Health show estimates that non-basic pay forms 20% of grade A average earnings, 15% of grade D, 10% of grade G and 5% of grade I. Overtime and shift payments in particular, and psychiatric lead allowances in the two lowest grades, form an important part of overall pay in the lower grades in the hierarchy. These payments are even more important for part-time staff. The data illustrates that the lowest paid nursing staff have not seen any great proportionate increase in the tranche of pay which benefits them most directly, and suggest that these elements should also be considered when assessing nursing pay outcomes.

The extension of non-pay benefits would make a focus on basic pay scales and the use of external pay comparisons inherently more problematic. Non-pay or social benefits provided by the NHS are not particularly generous in comparison with other public and private sector employers, and the NHS offers few examples of payments substantially above the statutory minima for maternity, sickness, and redundancy. However, the extension of non-pay benefits, such as assistance with accommodation, provision of creches, career-breaks and 'keep in touch' schemes, flexible working patterns, and staff development opportunities, has been viewed as an important means of enhancing equal opportunities and thereby improving the recruitment and retention of nursing staff, and may become more significant in the future. As Chapter Four demonstrates, there is some dispute between the Sides over the extent and pace of change in this area.

These reservations apart, further problems arise when illustrative data is drawn from nursing pay scales without considering the distribution of staff across the pay scale. In fieldwork interviews some managers mentioned that pay adequacy could be demonstrated by the fact that nurses can now earn some £20,000 a year. The force of this argument lies in the idea that this is a realistic ambition for a nurse and that 'sufficient' numbers of nurses are to be found at the upper end of the spine as to constitute a 'norm' rather than an exception. In this respect numbers in each grade and the freedom of movement up the clinical grade spine become important indicators.

At this point however data delays and deficiencies become very apparent. The following information has been compiled from a number of official sources. The distribution of nursing staff across the main grading structure is in fact very uneven as can be seen from Table 5.4. Five grades, comprised of student nurses and grades A, D, E and G, contain around 76% of all nursing staff. Some 72% of staff are in grade E and below and the majority of staff are actually to be found in grade D or below (including students) with basic pay ranging from £6440 to £11720 (Dec 1991 figures). The process of clinical grading is still continuing, but this data is at least indicative and

serves to put the much-cited £20,000 in context. It includes some of the increases accruing to nurses from successful appeals, particularly in grades B, D, E and G.

TABLE 5.4 DISTRIBUTION OF NURSING STAFF BY GRADE

Pay grade	whole-time equivalents in 1990	
	Number	Percentages
Senior nurse 8 +	2,800	0.6
Grade I	6,600	1.4
Grade H	10,800	2.2
Grade G	64,200	13.2
Grade F	31,300	6.4
Grade E	83,900	17.3
Grade D	73,300	15.1
Grade C	22,300	4.6
Grade B	21,600	4.5
Grade A	92,000	19.0
Student Nurse	55,100	11.3
Pupil Nurse	2,700	0.5
Teaching staff	6,900	1.4
Post-registration student	9,800	2.0
Other nursing staff	2,200	0.5

SOURCE: Pay Review Body (1992:23)

Unpublished data from the DoH also suggested that for a comparable period at least half of all nursing staff were on the top of their scale, with the exception of 1st level registered nurses on grade D where 26% were at the top. The percentage of staff at the bottom of each pay grade was more variable, ranging from 13% at the lower end of the hierarchy, 42% of 1st level registered nurses on grade D, and lower than 6% for grades F and above. These figures reveal a certain grade 'stickiness' and suggest that movements from grade to grade do not take place in any 'free flow'. There are, in fact, a number of important reasons for restrictions on freedom of movement up the clinical scales. These include interpretation of grading criteria, availability of training, requisite entry qualifications, availability of promotional posts, and funding constraints at local and national level.

Bearing the above problems in mind, pay scales are nonetheless useful for exploring changes in differentials. Although marginal adjustments in differentials towards unqualified staff were made in the seventh and eighth PRB recommendations, these went against the main trend of the 1980s as could be seen in Table 5.1. On the whole, the Pay Review Body has recommended and presided over a general widening of differentials internal to nursing. The introduction of Clinical Grading has made it harder to compare like with like, particularly for scale maxima. However, some comparisons are possible. For instance, a nursing auxiliary aged over 18 can be compared with a relatively newly qualified registered nurse (grade D) for the PRB period. Table 5.5 does this and shows a clear increase in differentials, particularly between Staff Nurses and the lowest paid auxiliaries, despite the emphasis in two of the later reports on improving the position of the low paid. This widening of differentials has been one of the most notable outcomes of the pay review process.

TABLE 5.5 DIFFERENTIALS OVER TIME, GRADES A AND D

Minima					
1984	Nursing Auxiliary	3530	Staff Nurse	4998	Differential 42%
1992	Nursing Auxiliary	7000	Staff Nurse	10820	Differential 55%
Maxima					
1984	Nursing Auxiliary	4512	Staff Nurse	6094	Differential 35%
1992	Nursing Auxiliary	8570	Staff Nurse	12400	Differential 45%

SOURCE: Calculated from Appendix A in PRB Reports 1 and 9.

USE OF COMPARISONS

Although they are inherently problematic, comparisons between increases in or levels of paybill, basic pay and average earnings, and of pay movements over time, are the most commonly used forms of indicator on nurses' pay. Trade union and management side negotiators naturally select the particular comparators, for the particular time periods that best suit their bargaining arguments, and choice of comparators varies from year to year according to internal and

external wage settlements and outcomes. Outside of the negotiation or pay review process commentators may seek to offer neutral interpretations, but are again confronted with many of the same problems found in assessing pay bill and pay scale measures, as well as some additional problems created by the exercise of comparisons.

Comparisons can be made at an aggregate or disaggregate level and emphasise either increases or levels. Problems involved with the use of the highly aggregate measures of the pay bill were emphasised in the previous section, as were problems with the less aggregated data on pay scales. The more highly aggregated measures of paybill and of comparators are usually put forward by Management Side. However, these measures are sensitive to the choice of base date and they have thus occasionally been used by Staff Side where a convincing argument can be made. NES data can also be problematic. This data is also fairly aggregated, and because the survey takes place at the beginning of April, the published results often exclude the effects of staging. Comparisons based on increases in rather than levels of pay tend to emphasise settlements on an annual basis, usually at a highly aggregate level. Despite an apparent 'historical' flavour these tend to take no account of nurses' absolute position vis a vis other groups of workers in the wage hierarchy over the longer period, or of any specific and disaggregate factors pertaining to nurses. At the same time, however, the choice of degree of disaggregation and of comparators for the evaluation of pay levels can also appear subjective and contentious. Hence the different types of comparisons made have particular strengths and weaknesses, which can be evaluated through a review of evidence on nurses' pay.

Cost-of-living Comparisons

In most years of the PRB the paybill increase has been above the RPI, even allowing for the effects of staging, and with the strong effect of clinical grading has averaged out as a fairly unambiguous increase in real pay. However, because of problems with the paybill measure, the true extent to which real pay has increased is considerably more

TABLE 5.6 PAY INCREASES AND THE RPI

NURSING AND MIDWIFERY STAFF: MOVEMENTS IN PAY RATES 1974-1991 (a)

Pay Round Year (1 August to 31 July)	Percentage Increase in Cash Pay (b)	Percentage Change In RPI (July)	Percentage Increase in in Real pay (c)	Percentage Position 1973/74=100
1974-75	20 (d)	26.3	- 5.0	95.0
1975-76	8	12.9	- 4.3	90.9
1976-77	5	17.6	- 10.7	81.2
1977-78	10	7.8	+ 2.0	82.8
1978-79	10	15.6	- 4.8	78.8
CUMULATIVE 74-79	64.7	108.8 (e)	- 21.1	
1979-80	21.0 (f)			
	14.0)			
1979-80	37.9	16.9	+ 18.0	93.0
1980-81	6	10.9	- 4.4	88.9
1981-82	-	8.7	-	
1982-83	12.3 (g)	4.2	- 0.9	88.1
1983-84	7.5	4.5	+ 2.9	90.7
1984-85	8.6 (h)	6.9	+ 1.6	92.1
1985-86	7.8	2.4	+ 5.3	97.0
1986-87	9.5	4.4	+ 4.9	101.8
1987-88	17.9	4.8	+ 12.5	114.5
1988-89	6.8	8.2	- 1.3	113.0
1989-90	9.6 (i)	9.8	- 0.2	112.8
1990-91	9.7 (j)	5.5	+ 4.0	117.3
CUMULATIVE 79-91	242.5	130.3	+ 48.7	
CUMULATIVE 83-91	108.6	56.9	+ 33.0	

Notes:

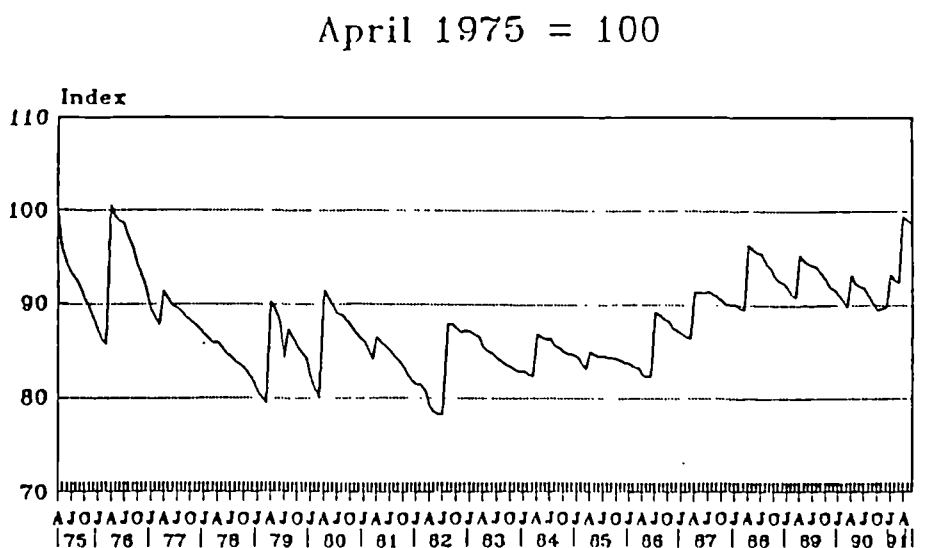
- (a) Figures reflect the full cost of the appropriate award, not changes in average earnings
- (b) Percentage cash increase reflects full year effect of increase agreed within the pay round year (1 August to 31 July)
- (c) Percentage real increase reflects the percentage cash increase for the pay round year deflated by the increase in the RPI throughout the pay round year, that is in the 12 months to July
- (d) Excludes pay settlements in Apr 74 =11% & May 74 (Halsbury)=30%
- (e) The percentage change in the RPI is that from July of the base year to July of the latest year
- (f) Cumulative effect of 2-stage Clegg awards paid 1 Aug 79 & 1 Apr 80
- (g) Two-year award paid wholly in 1982-83 pay round year
- (h) Payment straddled 2 pay rounds (5% from April 85 and 2.5% from Feb 86) but is expressed as 8.6%. The alternative would have been to count the second stage as part of the 85-86 pay round year
- (i) Staged award; 7% paid from 1 April 90, balance from 1 Jan 91
- (j) Staged award; 7.5% paid from 1 April 91, remainder from 1 Dec 91

SOURCE: Based on Management Side Evidence, 1991:15

contentious than Management Side, for example, have sometimes suggested, as is the significance of such an increase. Different groups of nursing staff have fared differently with respect to real pay increases. Chapter Four noted that cost-of-living measures are relatively meaningless unless some information on historical or comparative contexts is also included. Staff Side have also argued that the RPI is not suitable for some groups of staff, particularly 'low paid' for whom a low pay price index might be more appropriate.

An example of the different uses made of comparisons employing the RPI can be seen in Table 5.6 and Figures 5.1 and 5.2. Table 5.6 was included in Management Side Evidence and has appeared in previous years (MS Ev 1991:15-16). The notes to the Table illustrate the contentious nature of the exercise, particularly with respect to the choice of boundaries for time series. For example, the Halsbury award is excluded from the earlier period and the Clegg award is included in the later period. There is thus a tendency to 'claim' favourable data for particular political administrations and pick a low starting point.

FIGURE 5.1 REAL WAGES FOR NURSING AUXILIARIES (SCALE MINIMUM)

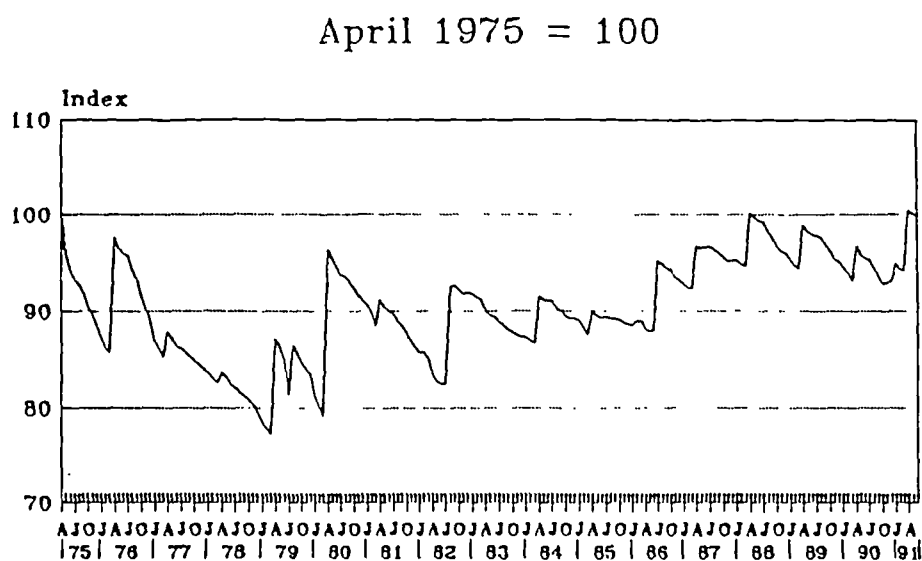


SOURCE: Staff Side Evidence 1991:4.6

This kind of comparison also tends to neglect the economic and political context in which wage settlements occur. In particular it could be argued that it is easier to award wage settlements in excess of the RPI when inflation is 'low'. The strong effect of clinical grading is also clearly visible.

Figures 5.1 and 5.2 were included in Staff Side Evidence (Charts 4.6 and 4.76, 1991) and use pay scale minima and maxima for nursing auxiliaries to show that real wages for this group of staff have fallen below their 1975 level (which includes the Halsbury award) for nearly all of the period to the present, only just catching up in 1991.

FIGURE 5.2 REAL WAGES FOR NURSING AUXILIARIES (SCALE MAXIMUM)



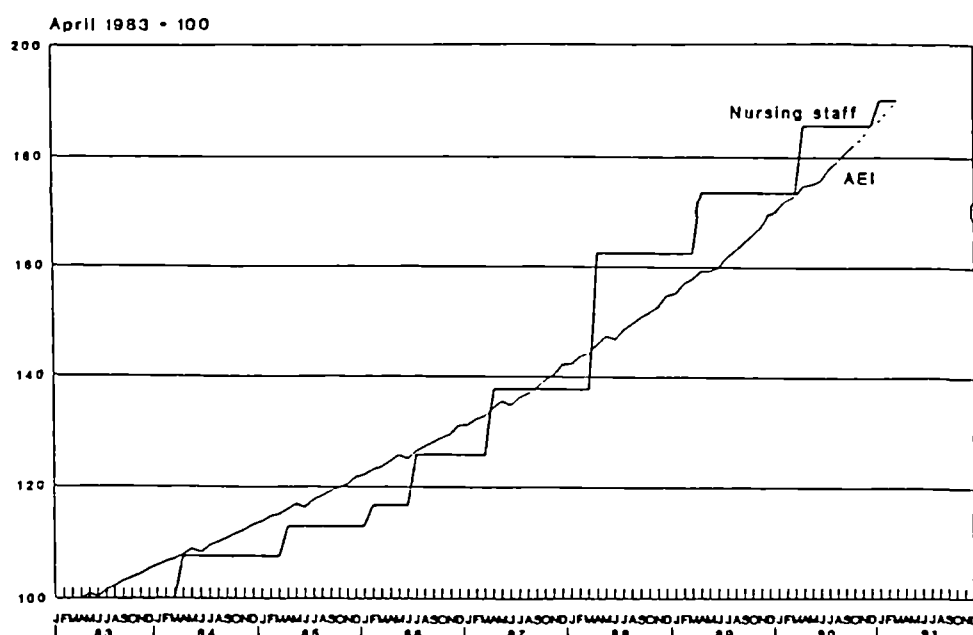
SOURCE: Staff Side Evidence 1991:4.76

Comparisons against Average Earnings

The average earnings index gives a rather better indication of relative increases in pay in that the AEI is directly related to going settlements elsewhere. Figure 5.3 illustrates 'nursing staff earnings

increases since 1983 compared with increases in the underlying AEI', and is notable for being the only graph to be included by the N&M PRB in any of their reports (see PRB,1991:42), suggesting that the AEI may be carry more importance in pay review than is evident from the process. The graph, unfortunately, did not carry any explanatory notes to say how nursing staff earnings or the underlying AEI had been calculated for this exercise.

FIGURE 5.3 NURSING STAFF EARNINGS INCREASES COMPARED WITH AEI



SOURCE: PRB Report, 1991:42

Once again the measure is a contentious one. Staff Side have noted that the AEI used for this graph includes manual as well as white collar earnings increases. As 'non-manual earnings have been increasing more rapidly than manual earnings for a decade' they suggest that this is 'the wrong index to use for nursing staff providing patient care' and that 'closer comparisons with other professional and white collar employees' are to be preferred (1991:5).

It is also the case more generally that comparisons with highly aggregated measures such as average earnings are bound to include depressed wages elsewhere in the economy and may therefore reinforce disadvantage, a point noted in interviews with trade union officials, who stressed the importance of this factor for women. However, taking it on its own merits, the strong uplift of clinical grading can again be noted as can the fact that before 1988 'nurses' were not doing very well against the economy-wide 'going rate'. Nursing staff pay increases have subsequently fallen behind again. The AEI was made a primary focus in Staff Side Evidence for 1993, where it was argued that pay increases had fallen behind AEI increases since 1988 (1992:4).

Other Comparisons of Increases

Finally, comparisons of increases can also be made within nursing, with other NHS staff, and against other groups in the public and private sector. The widening of differentials has already been noted, but this can also be demonstrated using the measures of comparative increases or comparative levels. A widening of relativities between nursing and other groups in the NHS has occurred and this has been used by Management Side to show that review body groups in the NHS have performed better than non-review body groups, and better than most other groups in the public sector (1991:13). Using such measures, Management Side have argued that the average pay settlements for nursing staff 'have tended to be higher than those elsewhere' (ibid). Such measures are widely used in academic commentaries (see, for example, Bailey & Trinder, 1989; Harrison et al 1990:98), some of which suffer from the problems identified with the use of the paybill increase or basic pay. Studies employing NES earnings data are less problematic (see NIESR, and Brown & Rowthorn, 1990:5-7), although, as noted, the NES creates different problems for the evaluation of nursing pay.

Aggregate Comparisons of Levels

Comparative measures can also employ comparisons which stress 'levels' of pay rather than 'increases' in pay and these can be quite useful measures both at an aggregate and disaggregate level. In recent evidence, Management Side have made only one comparison using pay levels rather than pay increases. For the 1991 and 1992 reviews they expressed average pay for Grade E as a percentage of pay for non-manual employees in the public and private sectors. The exercise for 1992 is reproduced as Table 5.7.

TABLE 5.7 AVERAGE GROSS WEEKLY EARNINGS (FULL-TIME STAFF)

		1984	1985	1986	1987	1988	1989	1990
(a)	(b)							
GRADE E Earnings (£):		134.3	141.5	159.7	174.8	218.2	234.9	275.0
NON MANUAL EMPLOYEES (c):								
PUBLIC SECTOR								
Earnings (£)		172.0	181.4	196.5	208.8	229.0	251.6	274.2
Average Grade E								
pay as a percentage		78.1	78.0	81.3	83.7	95.3	93.4	100.3
PRIVATE SECTOR								
Earnings (£)		172.3	187.0	203.9	222.8	247.6	272.3	300.2
Average Grade E								
pay as a percentage		77.9	75.7	78.3	78.4	88.1	86.3	91.7
ALL SECTORS								
Earnings (£)		172.2	184.6	200.9	217.4	240.7	264.9	291.2
Average Grade E								
pay as a percentage		78.0	76.6	79.5	80.4	90.7	88.7	94.4

Notes:

- (a) Before implementation of the clinical grading structure in April 1988, grade E did not exist. The 1984-87 figures therefore refer to the earnings of staff nurses
- (b) Estimated earnings of staff in post, based on returns from Regional Health Authorities and SHAs (Source: DH-Earnings Related Base of Data).
- (c) Earnings are for employees on adult rates of pay and whose pay was not affected by absence (Source: DE New Earnings Survey)

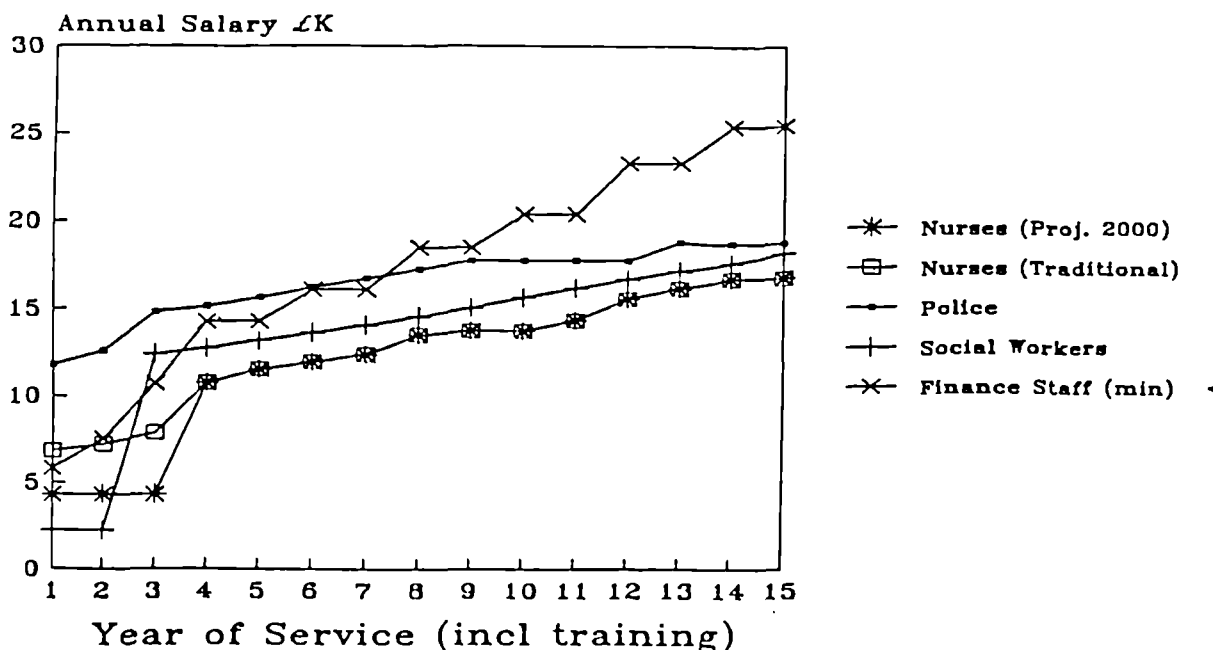
SOURCE: Based on Management Side Evidence, 1991, 1992:Table A4

It can be seen that this shows Grade E pay pulling up over the period against public sector, private sector and all sector earnings, although with the sole exception of the public sector, nurses can be seen to lie below their comparators so that this is perhaps a strange choice for Management Side. There are several points to note about the method employed here. Firstly, the comparison uses Earnings Related Base of Data (ERBOD) figures against NES figures and this introduces questions of data compatibility. Secondly, as was seen in the previous section, only a relatively small percentage of nursing staff are on grade E, with the majority earning less. In this respect, even though grade E may appear to be a mid-point on the clinical grading scale it does not necessarily approximate the majority experience of nursing staff. In addition, the highly aggregate comparator groups chosen introduce similar problems as those for the AEI.

Occupational Comparisons

It is common practice to compare specific occupations or groups of staff with groups or grades of nurses in the evaluation of relative

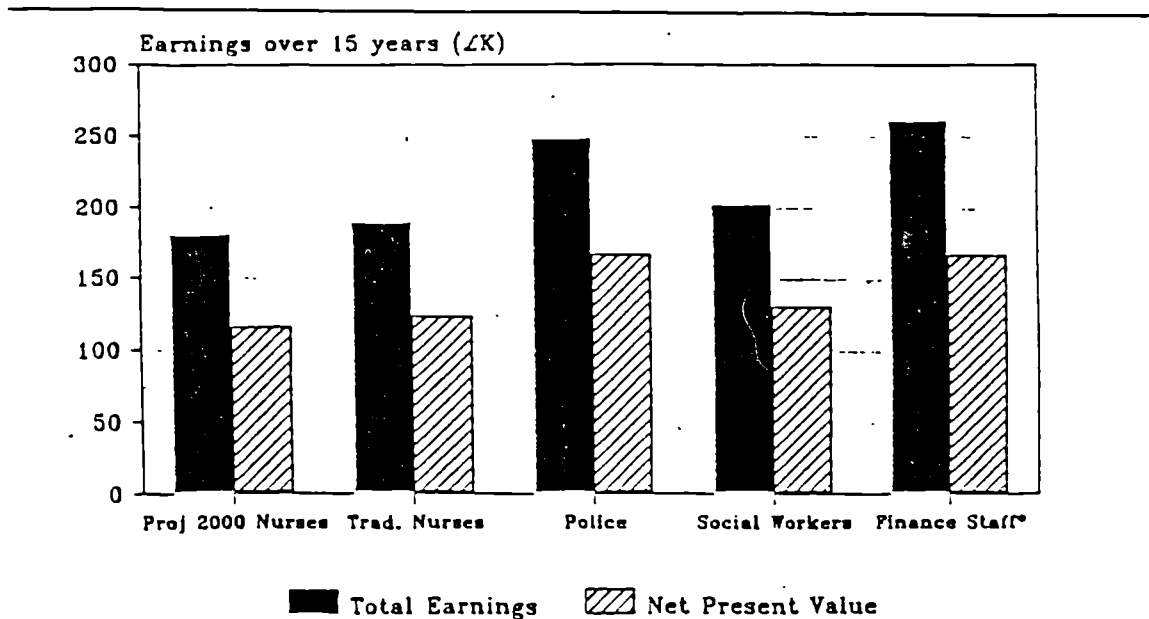
FIGURE 5.4 CAREER SALARY PROGRESSION



SOURCE: Staff Side Evidence, 1992:40

pay levels and career expectations. For example, in their evidence to the 1991 Pay Review Body, the Staff Side chose to link basic pay and length of service in their comparison between nurses, police and fire service staff. A particularly interesting exercise was conducted for the 1993 pay review exercise (Staff Side Evidence, 1992:39-40). Here Staff Side compared career salary progressions of nurses with those for police, social workers and finance staff ('typical bank employee') and then presented a form of discounted cash flow analysis for these different groups. The results are shown in Figures 5.4 and 5.5. This is an implicit form of comparing levels of pay. The choice of comparator group at this disaggregate level is of obvious significance, especially with respect to gender.

FIGURE 5.5 CAREER SALARY PROGRESSION



SOURCE: Staff Side Evidence, 1992:40

A more explicit form of comparing occupational levels of pay, by expressing pay as a direct percentage of comparator pay, can also be undertaken. Calculations from NES data show that, at the end of the 1980s, qualified nurses (below administrator level) earned approximately one third of doctors' pay and slightly less than ambulancemen. A possibly more appropriate comparison, based on length

of training and professional status, can be made with teachers. Qualified nurses earned approximately 80% of female primary teachers' pay, 75% of female secondary teachers' pay, and approximately 10% less in both cases, if the comparison is made with male teachers. Nurses, of course, are more likely to work unsocial hours than teachers. However, the choice of comparator is again contentious and historically changeable. Teaching also tends to be a gender segregated occupation.

In Evidence for the 1992 review, Staff Side conducted one of their most detailed comparisons of pay levels so far (1991:Section 3), with the explicit intention of substituting their own exercise for the long-awaited and unforthcoming comparability exercise promised by the PRB after clinical grading. It again suffers problems from the combination of ERBOD and NES figures and choice of comparators, but stands as one of the most carefully argued comparisons in the history of the PRB, and uses a form of job content evaluation. The graphs show nursing pay in each grade as lower than comparators (even including shift and bonus pay). Staff Side here made what some might regard as a very modest claim for each group with a detailed and compelling argument but the PRB did not appear to attach particular significance to this exercise in its recommendations. Staff Side have in recent years also measured Grade A earnings against Local government care assistants showing the former to be lower. This has great ramifications for the developing linkage between NVQs across the NHS and social services.

Low Pay Levels, Equal Pay and Differentials

The use of comparative levels is particularly appropriate for establishing the extent of low pay in nursing. Staff Side for many years have produced graphs comparing nurses' basic weekly pay rates (maxima and minima) with the Council of Europe decency threshold, indicating that auxiliaries were below the threshold on both calculations, and enrolled nurses on Scale C, on one of them (SSEv 1990:21). For 1992, Staff Side used ERBOD data to show that over 62%

of nursing staff in Grades A, B and C, and nearly 21% of the total nursing workforce, still earn less than the Council of Europe Decency Threshold (1991,Section 4:33). Staff Side have also highlighted the particular problems of part-time staff on lower grades (ibid:36). The Low Pay Unit recently published data showing that 62% of part-time auxiliaries, and 12% of enrolled nurses, were paid below its Low Pay Threshold (66% median adult male earnings) although these findings compared relatively well with other occupations in which female part-timers are concentrated (Low Pay Unit, 1991:14).

NES data, albeit problematic, permits some estimate to be made of progress on low pay during the Pay Review Body period. In 1983, the year before the PRB was in full operation, between 25% and 35% of full-time qualified female nurse and midwives, and between 46% and 66% of nursing auxiliaries, were low-paid under the Council of Europe decency threshold definition (less than 68% of full-time mean earnings). By 1992, between 17% and 25% of qualified female nurses and midwives, and 65% to 88% of nursing auxiliaries were low-paid under this definition. It is thus likely that qualified nurses have improved their position, although NES data do not allow a more precise measurement of the extent of improvement. However, it may clearly be seen that unqualified nurses have seen little or no improvement and may actually have seen a deterioration in their position.

It was noted earlier that differentials by qualification have increased over the PRB period and this change can also be viewed against NES data on average earnings and dispersion of earnings. In 1983, the differential between qualified nurses (registered and enrolled) and nursing auxiliaries was some 18%. By 1992, this differential had widened to 37%, again suggesting that qualified nurses have fared better than unqualified nurses over the PRB period. The widening of differentials can also be viewed against the economy-wide dispersion of earnings and changes in it. Whilst there has been little change in the number of full-time adult employees earning less than the full-time mean between 1983 and 1992 (around 60%), in 1983 less than 25% were low-paid under the Council of Europe definition

whereas in 1992 more than 28% were low-paid. Against the cut-off point for the lowest-paid quarter of employees, qualified nurses earned some 118% in 1983 and had improved their position to some 153% in 1992. By contrast, nursing auxiliaries earned 96% in both years and had therefore not improved their position amongst the lowest-paid in the economy.

Judged against the full-time mean for economy-wide earnings a rather interesting picture emerges. The 'cut off point' for the lowest 25% of full-time adult employees as a percentage of average earnings was 70% in 1983 and had deteriorated to only 63% in 1992, fully consistent with the view that the lowest-paid in society have fared very badly in the 1980s. Consistent with this picture, nursing auxiliaries have seen their average earnings as a percentage of the economy-wide full-time mean deteriorate from 68% in 1983 to 61% in 1992. By contrast, qualified nurses have seen their average earnings improve from 83% of the economy-wide full-time mean to 96%, although it may be noted that such nurses still earn less than the mean which is already depressed by the inclusion of women in its calculation.

In Table 5.8 it can be seen that the average gross weekly earnings of nursing staff by gender varies despite equal pay legislation. The figures partly reflect what appears to be increased availability of paid overtime for male nursing staff and partly are a sign of vertical segregation and an apparent lack of opportunities (see also EOC, 1992:3-4). It may be seen that there has been some improvement since 1983. However, the differentials may have been widening again in the early 1990s (NES data is, unfortunately, inconsistent across time in the categories of staff included).

TABLE 5.8 GENDER DIFFERENCES IN AVERAGE EARNINGS

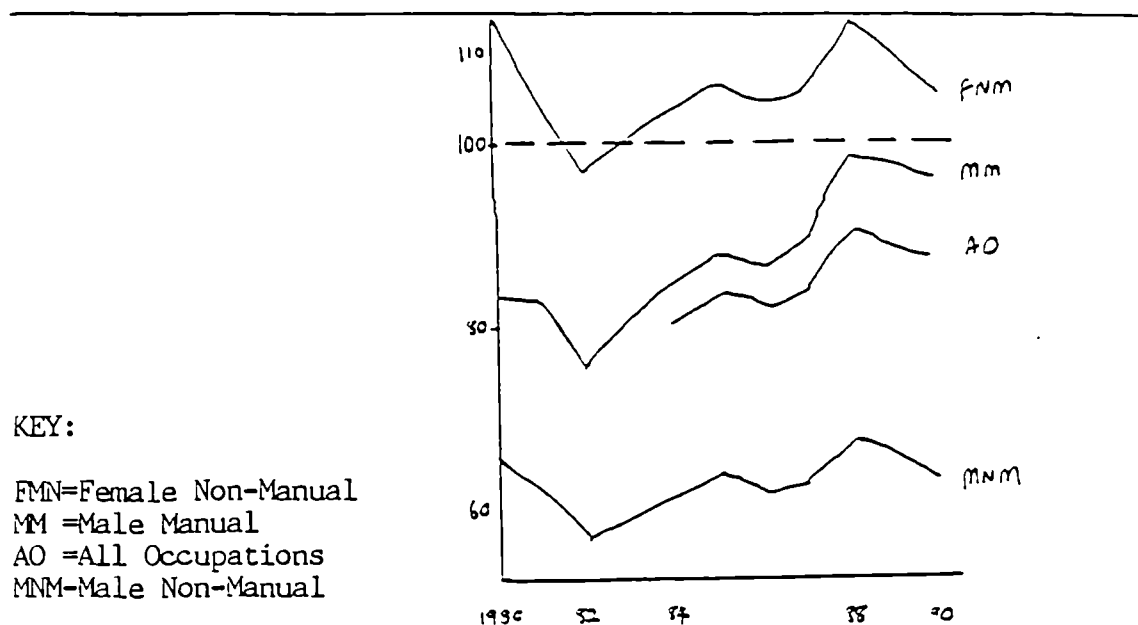
	1983	1990	1992
Differential Nurse Administrators and Executives (male/female):	14%	12%	n.a.
Registered and Enrolled Nurses	15%	6%	8.5%
Nursing Auxiliaries	n.a.	n.a.	15%

Source: NES, 1983, 1990, 1992

Comparisons Showing Increases and Levels Simultaneously

With respect to external comparisons, Figures 5.6 and 5.7 have been compiled from NES data and are perhaps the best available economy-wide indicators for nurses in terms of locating their pay historically in

FIGURE 5.6 QUALIFIED FEMALE NURSES' RELATIVE PAY AS A PERCENTAGE OF COMPARATORS, 1980-1990



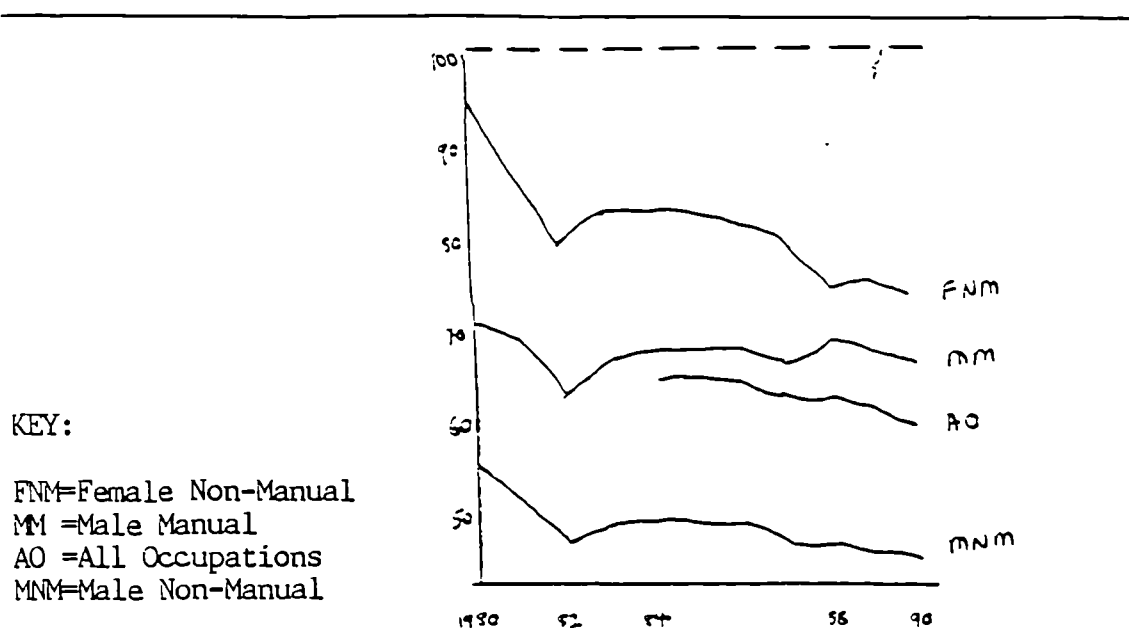
SOURCE: Compiled from NES data, various years.

the wage hierarchy and in evaluating gender inequalities and differential treatment according to qualified and unqualified status [1]. Figure 5.6 tracks the level and movement of female qualified nursing staff pay against those of four economy-wide comparators over the last decade. Figure 5.7 does the same for female unqualified nursing staff. The graphs indicate clearly the changes in relative pay of qualified and unqualified nurses, and the relationship between pay levels and movements for both groups against those of comparator groups. In the case of qualified staff, the 'high points' result from the pay award of the Clegg Comparability Commission in January 1980

[1] The NES data used in Figures 5.6 and 5.7 have been 'smoothed' to reflect increases broadly in the year in which they occurred. As this cannot be done for other groups, the figures tend to overstate nurses' pay. NES data conversely tends to understate qualified nurses' pay.

and the award linked to the clinical grading review of 1988. Over the whole decade, they have made little real advance from their position of around 65% of male non-manual earnings, and have slipped from the 1980 position to approximately 105% of female non-manual earnings. The gap between qualified nurses pay and that of male manual workers, and all occupations has been closing, although their pay is still below that of both groups. This is, of course, as much an illustration of the slippage in the relative pay position of manual workers through the 1980's as it is of the movement in nurses' pay. In the case of unqualified nurses (Figure 5.7), there has been a uniform decline from the position in 1980 against all four comparator groups. In sharp contrast to the experience of qualified nurses, there appears to have been no 'clinical grading' uplift.

FIGURE 5.7 UNQUALIFIED FEMALE NURSES' RELATIVE PAY AS A PERCENTAGE OF COMPARATORS, 1980-1990



SOURCE: Compiled from NES data, various years

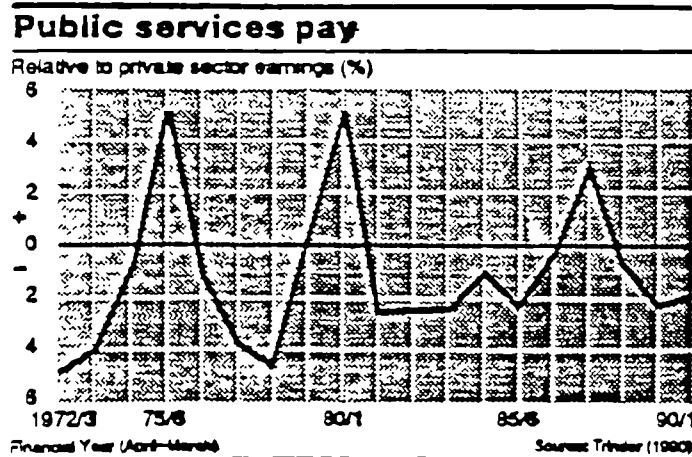
Taken together, the graphs clearly show the effects of horizontal segregation and widening differentials on nurses' pay. It can also be noted that nurses' relative pay position against most of these comparators still had not reached the Halsbury level at the time of the Clegg awards and that nurses in the late 1980s were only beginning to recapture the relative position they held after the Halsbury

recommendations in 1974, since which time they have experienced further slippage.

Public Service Pay Relative to Private Sector Earnings

A final point of comparison for nurses pay pertains to a broader argument on influences in wage determination. Figure 5.8 shows the relativity between public services pay and private sector earnings. If this graph is compared with Figure 5.6, above, it can be seen that peak points in nursing pay coincide broadly with peaks in public sector pay on electoral cusps. The evidence thus suggests that the impact of the PRB has not yet avoided the 'fall-behind' and 'catch-up' periods associated with electoral cycles, although very different reasons have been given in the pay review process for nursing staff pay uplifts.

FIGURE 5.8 PUBLIC SERVICES PAY AS A PERCENTAGE OF PRIVATE SECTOR EARNINGS



SOURCE: Trinder, 1990

CONCLUSIONS ON PAY OUTCOMES AND THE REVIEW PROCESS

As Buchan has succinctly noted 'analysis of pay trends is usually an inexact science, and often a partisan exercise' (1992:10). In reviewing pay outcomes the previous section has shown that different methodological approaches and measurements have different strengths

and weaknesses and has also given a flavour of some of the arguments made by the Sides and the PRB for pay outcomes from the review process. In particular, it has been stressed that the total paybill is an increasingly flawed measure by which to evaluate both nursing pay outcomes and nursing labour costs. The continuing force of earnings comparisons for evaluating pay outcomes is, however, evident from the discussion.

Assessment of the performance of nursing pay over the period of the Pay Review Body remains contentious in terms of the methodology and data employed and the level of aggregation. The study conducted here suggests that some broad conclusions can nonetheless be reached on the main pay outcomes. Despite a relative decline in aggregate public sector pay against the rest of the economy throughout much of the last decade, nurses (and police) have generally fared better than other public sector employees, and than the public sector as a whole (Brown & Walsh, 1991:55, Bailey and Trinder, 1989). Pay review arrangements have also generally appeared more beneficial to nurses than have collective bargaining arrangements for other groups of health service workers; for example, Harrison et al show widening differentials in salary scale maxima for selected NHS staff groups, and a relatively favoured position for qualified nursing staff (1990:98).

Within nursing one of the most striking outcomes over the pay review period has been the widening in differentials and the divergent experiences of qualified and unqualified nursing staff. Qualified nursing staff have seen real pay increases for most of the period (see also Buchan, Nursing Standard, May 20 1989) and for a brief period with the clinical grading review moved ahead of increases in the AEI. However, qualified nurses have made few gains in terms of their position in the national wage hierarchy, particularly against their closest male comparators, although they have improved their position against male manual workers and some public sector workers, groups which in general have fared badly through the 1980s. Comparisons of pay 'levels' also show that nurses still earn less than many seemingly 'appropriate' comparators. Substantial pockets of low pay remain,

particularly for ENs and part-time staff. In summary, the data with respect to qualified nurses 'does not reveal any massive pay uplift engineered by the Review Body' (Buchan, Nursing Standard May 20 1989), and suggests a number of continuing problems. By contrast, unqualified nurses have fared badly against the majority of comparators during this period, with real income losses, the persistence of low pay, and poor results overall in the clinical grading exercise. The most striking outcome during this period has undoubtedly been the extent to which both groups have shared the continuation of gender inequalities in levels of pay, within nursing and the NHS, and against most aggregate and less aggregate external male comparators, although unqualified nursing staff have fared disproportionately badly. In this respect, nurses as an overwhelmingly female and segregated workforce have made few gains and suffered some losses.

The structure, process and outcomes of the Nurses' and Midwives' Pay Review Body comprise a complex set of relationships and expectations. Part of the strength of the PRB system lies in the fluidity of interpretation that can be applied to outcomes and their underlying causes. It is possible to distinguish at least *two plausible* interpretive frameworks. On the one hand, it could be argued that there is a divergence between the apparent priorities of the review 'process' and actual pay outcomes. In Chapter Four, the pay review process was seen to be heavily dominated by the recruitment and retention criterion, with very little debate on cost of living, average earnings or differentials, which might have been considered more traditional priorities amongst wage determination criteria. By contrast, and in the light of the history of nursing pay and pay determination, the most remarkable aspect of pay outcomes is perhaps that they are unremarkable: widening differentials, while the PRB appears to make recommendations which are skewed in a hierarchical direction; pitched broadly, for qualified nurses, at rather less than AEI increases and rather more than inflation, thus showing the continuing importance of broad measures of comparability; effecting little change in historical inequalities in gender or in substantial

areas of low pay; and with clinical grading providing a temporary uplift, rather like a review within a review. Against the electoral cycle in public services pay more generally, and for nurses more specifically, Halsbury remains a large peak, while Clegg and clinical grading constitute smaller peaks, with the establishment of the PRB itself something of a blip. Fall-behind and catch-up periods have not disappeared, although it could be claimed that they have been smoothed out by the PRB.

Hence, over the period of the PRB nurses' pay outcomes reveal a broad picture which reflects and, by weight of numbers, reinforces wider trends in the economy: real increases in average pay for many, widening differentials in income, concomitant increases in low pay and ever-present gender inequalities in pay. In all, Barbara Wootton's observations in 1955, on the relative conservatism and rigidity of the wage hierarchy, do not seem altogether redundant if applied in the early 1990s to nurses.

On the other hand, it is possible to paint an altogether different picture. In this second interpretation of events, there is a mismatch between intentions and outcomes in pay review. The PRB first adjusted differentials to match the initially divergent needs of recruitment and retention. As shortages of unqualified staff appeared, differentials were re-adjusted. If shortages appear to have persisted, despite the recession and adjusted establishment figures, then this reflects in part the effects of government policy towards the implementation of the PRB recommendations. The PRB itself has issued annual warnings that this would affect outcomes. Similarly, 'interference' has dampened the effects of pay uplift recommendations, designed to produce consistency and reduce shortages through provision of a 'fair' going rate for nursing staff.

From the perspective of a pluralist reading of the role of the state, the absence of significant uplifts in pay is consistent with 'equity' for the taxpayer, although the PRB has not allowed the government's stress on 'ability to pay' to cloud its own judgement. As noted on

several occasions by the PRB, it is not for the PRB to concern itself with wider questions of low pay in the economy (or, presumably, questions of equality for women). In this context, clinical grading was not an 'electoral' blip - or a review within a review - but a serious attempt to reward nurses fairly for the job they do while improving the record on recruitment and retention, negotiated outside the PRB, but with subsequent recommendations on the pay rates to be applied. In this view, the PRB has done as well as it could in the delicate task of balancing the equitable demands of staff and taxpayer. This picture might be fairly consistent with the system as described by one of its, long-standing, members:

The pay review bodies have been established to exercise judgement, in order to determine what shall be the pay levels of groups of workers who find themselves in rather particular market circumstances. What they must do is exercise that judgement fairly, taking into account what all the interested parties draw to their attention but avoiding any slavish acceptance of any one view or argument. They are not in the business of doing simple sums or of applying simple formulae and their conclusions must inevitably be reached as an outcome of long debate and discussion (Thomason, 1985)

Through this application of judicial wisdom and fairness, the Pilkington priority of maintaining industrial peace can be satisfied. From this perspective, the evidence clearly shows that the PRB has been successful in reducing conflict over pay. Technically speaking, its recommendations are not binding, yet the government has generally accepted them and since the PRB has been in operation there has been no national industrial action over pay by nursing staff.

In recent years this perspective on the pay review process has received some support from Staff Side, particularly since the 1992 General Election and the increasing potential for a large-scale shift to local wage determination with the majority of hospitals scheduled to become Trusts by 1994. It is now an established part of the 'process' itself that Staff Side should reaffirm their commitment to the PRB in Evidence. Evidence for 1993 summarises their formal view that:

After the first ten years, we continue to view the Review Body as an appropriate and fair means of determining the pay of nursing, midwifery and health visiting staff, and regard its continuation as essential if the pay position of nursing staff is not to be undermined (September 1992:3).

The prospects - and now reality - of a public sector pay freeze, and the experience of a growing incidence of hospital closures and redundancies, prompted a Briefing from the trade unions (1992, kindly provided by COHSE) in which it was argued that the PRB had, 'by any criteria, whether of management, staff or patients...been a success'. This Briefing went on to suggest that 'unlike negotiations elsewhere in the public sector, it is not cash limited, cannot be manipulated by either side and attempts to resolve the interests of the Department, staff organisations, managers and the Treasury in a rational way'. Going further, the Briefing suggested that the PRB has indeed shown itself 'willing to respond to arguments on low pay'. Moreover despite continuing problems with nursing pay:

compared to the previous pattern of stop go in which periods of decline led to disputes followed by catching up exercises through commissions of inquiry it is a major advance.

The Briefing also argued that the Review Body has value in providing a national rate for the job as demonstrated by the experience of nurses in self-governing trusts (SGTs), the majority of which have preferred to follow PRB rates, and the private sector which also uses NHS rates as a benchmark. The PRB has benefited managers by obviating the need for annual pay campaigns and the threat of disputes which divert staff attention from service delivery. The associated pay cycle allows easier financial planning. Staff do not become demoralised quality of care has been ensured for patients and the public. National wage determination limits the scope for pay leapfrogging, the poaching of staff and local pay disputes. The PRB has also benefited Government, by ensuring industrial peace and minimising the recruitment and retention problems that might have arisen without such a system. The PRB has also 'depoliticised the issue of nurses' pay' and:

in recent years...has increasingly favoured government arguments by awarding lower rises than staff organisations would have liked...in response to Government calls for restraint and evidence that staffing problems have eased.

The Briefing, importantly, argues that:

The Review Body has worked and won staff support because it has acted independently. It makes recommendations based on what it believes to be the right salary levels, has taken action to ensure nurses are in their rightful place in the pay league and has given a hearing to arguments put forward by the organisations representing staff. All these ingredients are essential to its success.

The contents of this Briefing summarise most of the positive arguments for the review body system. The document, should of course, be understood in the very particular context in which was produced. It stands in interesting contrast to the initial responses to the Consultation document on the establishment of the PRB (Chapter Three), where some cogent and coherent tactical arguments in defence of the previous position were maintained. This illustrates the degree of tactical shift on the part of the unions as well as being a testament to their adaptability in formulating bargaining strategies.

However, these views can be compared with the findings of a series of formal and informal interviews conducted with union officers involved in preparing and presenting Evidence from all the major nursing trade unions. A range of views emerged from these interviews, some of which contrast strongly with the formal view expressed by Staff Side and the individual trade unions. An initial and common reaction to the pay review system was one of cynicism and mirth and the suggestion that, like the emperor's new clothes, the pomp and ceremony of the pay review process depends on a universal suspension of disbelief. There were, however, sharper underlying strands of opinion. Most officers exhibited, in varying degrees, some belief in the relevance of particular criteria in the wage determination process and the ability of the PRB to consider them seriously. Officers at one union seemed confident that they could predict outcomes by assessing the current political context and the sensitivity of the nursing 'issue'.

The Pay Review Body could be viewed from a social scientific perspective. It was constructed as a replacement for national

negotiation, which Staff Side strongly argued had 'broken down' mainly because of the disproportionate influence and power of government in the process, and in suppressing nurses' pay. The government response was to set up an independent and separate Review Body. However, the members of the PRB are appointed by government, the Terms of Reference are set by government, government provides Evidence, and government decides on the implementation and funding of recommendations, if it decides to accept them at all. As Seifert has shrewdly remarked with respect to the pay review process 'the government has several bites at the pay cherry' (1992:278).

However, the nurses' and midwives' pay review process, and the central role of the Pay Review Body, should not be characterised as a simple and unproblematic extension of the state apparatus, designed to suppress pay aspirations and limit potential conflict. This does not capture complexities inherent in the way pay review operates.

If the PRB were to make recommendations privately or directly to the government, and with no intervening process, then this would appear as a system of pay imposition, to be badly resented in years where awards were 'lean'. In the event, the review process, as mediated through the Pay Review Body, can successfully engage each Side in the pay determination process, while leaving a degree of freedom to the wider play of power both within and without the immediate context of the pay review exercise. It allows grounds for 'sufficient compromise', either through the actual concession of pay or the striking of a particularly sympathetic attitude. It is possible to make different interpretations of outcomes, and the process allows both Sides to claim a degree of success; for instance, Staff Side's version of the outcome for lower paid staff in the seventh and eighth PRB recommendations could equally be cast as a simple example of a device to aid recruitment and retention. The PRB indicates that arguments are taken seriously while the basis for its recommendations as a whole are left unexplained in detail. However, in the last instance the government determines pay settlements through its funding decisions on the non-binding PRB awards. Through mediation and accommodation the

PRB acts as both arbiter and buffer in negotiating the relation between government and Staff Side. The balance of its effects can be seen in the course of empirical pay outcomes and their reflection in the medium term viability of the pay review system itself.

The debate over pay in the review process and the criteria employed are better understood in this context. This analysis does not denigrate the sincerity of the individuals involved, or the validity of the arguments, but rather suggests that the review mechanism functions in a way which reflects wider social and political relations. For instance, it was noted in Chapter Four that the criteria and arguments have been skewed towards 'economism', both by the original Terms of Reference and market forces rhetoric of the government and the response of the PRB.

Even within these skewed terms of reference, however, Staff Side have had relatively little success in getting 'non-orthodox' economic arguments taken on board. Staff Side have argued on numerous occasions that low relative pay for nurses causes problems for recruitment and retention in the longer term. Taken on their own merits, such arguments would deserve consideration by the PRB. However, the PRB has nearly always rejected wider macroeconomic arguments or the 'longer term' efficiency arguments on comparability put forward by Staff Side. In contrast, and despite some strong criticism, it accepts that the 'ability to pay' criterion has some validity and has recently linked the government with taxpayers' interests. Staff Side arguments on low pay and equal pay are thus reduced to ones of 'equity' or placed on the margin of the process. When Staff Side have challenged the government's notion of resource financing in the macroeconomy, this too has been rejected. For instance, Staff Side have frequently put forward Keynesian or post-Keynesian arguments to the effect that low pay is a cause of insufficient demand in the economy (for example, see COHSE document, November 1992:2-5). On this view, unduly suppressing public sector or nurses pay would not produce 'equity' for the taxpayer because it is an inefficient macroeconomic policy.

In this respect, an important material effect of the Process is to rule certain theories or criteria 'out of court' and therefore limit the force of these arguments in the subsequent media coverage and internal union discussion of process results and aspirations. This does not prevent unions pushing more strongly on criteria which have a similar effect on outcomes or adopting different, and possibly more successful arguments, but it sends a strong signal on the limits of the exercise.

Finally, an important part of the pay review process is in its very remoteness and in taking nurses as a special case. In this respect, a number of important external influences on process and outcomes are obscured. Firstly, the PRB was more or less explicitly offered as a 'sweetener' to nurses. This divided nurses from other NHS staff but it could be argued that their pay and conditions of work are deeply inter-dependent. Linked to this are the important effects of employment levels, grading and training, and wider decisions on healthcare for nursing pay. These are the 'underlying issues' which, although they appear in certain parts of the process, are not evaluated in any integrated way. The importance of negotiation in the NMSNC nationally and over clinical grading appeals locally and at higher levels is also an important and largely obscured part of the pay review process and outcomes. The remoteness and specialisation of the review process could therefore also produce material outcomes through attitudinal influence.

The above aspects of the pay review process may have had an important material influence on trade unions and their activity. Both in the manner of its establishment and in its bias towards qualified staff, the PRB may have re-established the status quo in favour of 'professional' unionism. The RCN has grown substantially in the 1980's whilst the TUC trade unions' membership has remained roughly constant. In the industrial relations climate of the 1980s this may illustrate a measure of success for both the RCN and the TUC unions, the latter in particular. However, in the light of nursing history, it has additional connotations. The reasons for fluctuations in

nursing union membership remain poorly researched. To some, the no-strike element of the establishment of the PRB and the RCN's adherence to this was an important factor in the RCN's growth (Beaumont,1992:58). The RCN's earlier introduction of indemnity insurance could also be important (Carpenter,1988) as could its increasingly 'trade union like' behaviour. However, compositional changes may also have been an important factor in these developments, the effect exacerbated by the review process and the widening of differentials. The remoteness of the exercise and a relative lack of militancy over pay during this period may also have been significant.

At another level, however, the pay review process may have had some quite unexpected and contradictory effects on trade union activity. Carpenter has argued, for example, that:

the PRB system has also compelled unions to prepare their case much more thoroughly than was the case through over-the-table pay bargaining...[and has]...also promoted greater cooperation between staff side organisations, especially in order to respond to government interference in their affairs (1988:390).

These points were emphasised in Chapter Four on process (see especially low pay) and were also substantiated in interviews with trade union officers.

At the same time, the RCN and TUC unions have had a considerably heightened level of local activity through the clinical grading exercise. In fact the TUC unions, with traditionally stronger local organisation, may have excelled. The grading exercise is so deeply interlinked with pay as to almost constitute local pay bargaining and interviews at national and hospital level revealed a corresponding increase in confidence on the part of trade unionists with respect to local bargaining. This may also have promoted some cooperation between the unions through the national negotiation process and subsequent appeals at lower levels, though differences have still been apparent. These effects raise some important considerations for decentralisation of wage determination.

The PRB is a complex and contradictory institution of government which reflects, reinforces and, in some respects, alters the balance of power. Its contradictory nature is clearly seen in one of the most important and visible outcomes of the process, which has been the apparent ability of the PRB to generate ambivalence regarding the boundaries of its role with respect to pay determination, both on the part of government and Staff Side. This has occurred on three main issues which, although linked, are often incorrectly conflated as the 'decentralisation' issue; respectively, fragmentation, decentralisation and individualisation of wage determination. Decentralisation is explored in more depth in subsequent chapters, but a brief summary and tentative analysis is now given of the role of the PRB in this process.

Fragmentation in wage determination might be defined as the removal of groups of staff from joint methods of determination or procedures. The establishment of the PRB fragmented the Whitley system and split nursing staff from ancillaries and other NHS groups. However, within the review process itself, auxiliaries have been increasingly polarised from qualified nursing staff and senior nurses have, for several years, had their pay recommended separately by the PRB. Both of these groups have seen their pay deteriorate relative to the qualified clinical grades. Somewhat 'externally' to the review process, the NHS reforms have meant further fragmentation. The new staff group, health care assistants (HCAs), who overlap greatly with the auxiliary role, have been excluded from the pay review process altogether, although Staff Side have argued for them to be included. New employees in Trusts and transferred staff who change contracts can also have their pay determined locally and are now in an ambiguous position with respect to the official remit of the PRB, although PRB rates are currently still followed in the majority of Trusts.

Decentralisation of wage determination refers to the lowering of the level at which determination takes place. This has occurred 'externally' through the provisions for local bargaining for HCAs and Trust staff in the NHS reforms. However, and importantly, it has also occurred through the review process itself in the form of London and

flexible pay supplements. Here a light is once again cast on the role of the PRB, which has frequently 'jumped the gun' on negotiations and enabled these projects to go ahead, despite its own reservations and criticism. The amount of money involved in these projects is marginal compared with the total wages bill, but has increased managerial prerogative to some extent and reduced the force of national level determination.

Individualisation of wage determination refers to the devolution of pay determination at national level or staff group level to a more individual level. The PRB itself has noted the apparent confusion of the government over flexible and performance-related pay. However, flexible pay has also enabled pay determination to become increasingly individualised, particularly in its functional rather than geographical forms, as there has been little control over the process and payments accrue in the form of an additional tranche of pay to individuals. Performance pay has been brought in for senior nurses and some clinical nurses and enhances this effect. In theory clinical grading has also enabled a greater degree of individualisation of pay.

Identifying the different conceptual elements involved in 'decentralisation' clarifies inconsistencies in its logic. The gearing of pay determination towards local labour markets and individual performance involves two entirely separate concepts and incompatible objectives, even if performance pay only acts as a component in pay. Awarding pay increases related to improvements in productivity at whatever level does not solve for labour market equilibrium except under the most stringent assumptions of perfect competition and general equilibrium.

As was shown in the previous chapter, the PRB process has had an interesting role in highlighting policy plans and additional inconsistencies with respect to decentralisation. The policy proposals outlined in the ninth PRB report (1992:see especially 3-6) exhibit a degree of ambiguity on the part of government towards the progress of decentralisation. The NHS reforms have as their logical conclusion

the total decentralisation of pay in the 1990s. The HDs claim that over the next few years Trusts will be breaking away from national rates determined through the PRB system and that, meanwhile, Trusts are 'increasingly using the Review Body recommendations as a benchmark from which to set their own pay rates' (1992:6). The HDs are also proposing that 'in future the Review Body would be invited to recommend a "target average percentage pay increase" (TAPPI) for nursing staff' (1992:4) of which a proportion would be available for flexible pay. However, at the same time it is calling for greater local managerial prerogative in pay determination, argued for in the Warlow Report and included in the Citizen's Charter, the government is striving to retain centralised control through basing funding on the TAPPI and 'requiring health authorities to ensure that the overall net effect of all the changes was an average pay increase for nursing staff in each of their units in line with the TAPPI figure' (1992:4). The government's position towards funding arrangements for Trusts when and if they develop their own pay determination arrangements is unclear but the above arrangements suggest that de facto financial controls and formal or informal pay networks may give limited scope for radical individualisation of pay or relating pay to productivity.

Paradoxically, the PRB process, at a time of increasingly chaotic policy on the part of government, may have heightened Staff Side's interests in decentralisation through the collection of pay data and perception of outcomes and the clinical grading exercise. Interviews revealed a growing, if private and minority, strand of opinion within particularly the TUC trade unions that local bargaining may not be such a bad option, especially if the remoteness of pay determination has alienated staff from responsibility for their own conditions and reduced the perceived role of unions. As noted, the amount of negotiation that still takes place is largely obscured in this process. Clinical grading, though it had its disappointments, also gave the unions confidence and increased expertise at local level in pay-related representation and also demonstrated the degree of overt and less overt conflict such an exercise could produce. Interviews with local union officials, in particular, suggested a degree of

speculative interest in further local bargaining of this type and officials also reported a growth in membership through this exercise. Whilst a certain amount of revived interest in local bargaining might be bravado and there are concerns about weaknesses in some geographical and functional areas and potentially uneven outcomes (see also Buchan's results, 1992:21), some part of this interest is undoubtedly based on a relatively negative appraisal of nursing pay outcomes through national wage determination, both prior to and during the PRB.

As both Sides consider their position on decentralisation, the pay review process and future evaluation of its effects is becoming increasingly indeterminate. As the PRB notes:

For our part, we shall need information on the earnings of individual grades of staff in DMUs and Trusts, as well as manpower data, if we are to continue to make recommendations on remuneration. We will not be able, for example, to judge the appropriate size of the flexible element in year two if we do not know how it was being used, and what were its effects on performance and productivity, in year one. We will not be able to interpret, and report on, trends in recruitment and retention in the NHS as a whole if we do not know what is happening in the Trusts (1992:6).

The increasingly chaotic state of pay determination for nurses may, in part, stem from a certain lack of analytical clarity on the theoretical role and material outcomes of pay review. The variety of complex interpretations that might be placed on these, and the unexpected feedbacks to the system, have undoubtedly obscured the policy costs and benefits of pay review. However, the major effect of the pay review process may be to suppress wage expectations whilst nonetheless it fails to tackle material sources of conflict. If conflict is driven to lower levels or material concerns are reflected in the traditional problem of shortages, then it could be argued that the PRB is, in common with prior systems of review, a flawed institution. However, decentralisation may not be the solution under this form of analysis. A final evaluation is made of pay review and decentralisation after an exploration of local and 'non-pay' issues.

CHAPTER SIX

THE IMPACT OF NATIONAL DECISIONS ON LOCAL MANAGEMENT

The views of local management have usually been excluded from the process of nursing pay determination. As the direct employers, however, local management are at the sharp end of decisions taken on pay and related issues such as funding of pay awards, grading structures and changes in training. This chapter explores the effects of national decisions on local management, and highlights the significance of pay-related or 'underlying' issues and the current scale of the 'crisis' in nursing demand and supply as seen by local managers. It reports the results of fieldwork interviews with management conducted in eight District Health Authorities (DHAs) throughout the West Midlands Regional Health Authority (RHA), the largest RHA of the fourteen existing in England and Wales in the early 1990s.

BACKGROUND TO THE FIELDWORK RESEARCH

As noted in Chapter Two, a number of major changes were made in the structure and management of the NHS in the 1980's. Firstly, the tier of Area Health Authorities was abolished in the 1982 NHS reforms, and DHAs became the main intermediary link between hospitals and RHAs, with units overseeing particular aspects of the district's work, such as acute care. Secondly, in 1983, the Health Secretary asked Sir Roy Griffiths of J. Sainsbury plc to appraise the NHS management style. His findings 'highlighted the absence of identifiable leaders within management, the fact that it was often difficult to establish who was in charge in a particular locality and the woolliness and inefficiency of consensus management' (NAHAT,1991:5). His conclusions were accepted by the government and led to the creation of a general manager at every level from national to unit, and the creation of NHS supervisory and management boards which subsequently became the policy board and NHS Management Executive (NHSME) respectively. With

particular relevance for nurse managers, the 'professional background of officers became less important than an individual's abilities' (ibid). General managers were appointed on short-term contracts and some of their earnings were to be performance-related. Many came from commercial or non-NHS backgrounds. The priorities attached by Griffiths to the development of outcome measures, and the greater involvement of clinicians in management and the resource management process, have also had a strong impact on the management ethos in the NHS.

The NAHAT report (ibid) suggested that it was the financial crisis of 1988 which prompted Margaret Thatcher to announce a further review of the system which led to the 1989 White Paper 'Working for Patients', produced by Kenneth Clarke as Secretary of State. The 1990 NHS and Community Care Act encompassed fundamental changes of direction, with one among many different emphases being to further inculcate 'free market' values into the NHS. The concept of the 'internal market' was that funding would follow patients to more efficient provider units. HAS were to purchase health care on behalf of their resident populations via contracts, according to their needs and GP referral patterns. Hospitals, community health units and other services would also be able to become NHS Hospital Trusts, giving them direct control over their own operation. The larger GP practices would be able to apply for fundholding status and thereby be able to purchase direct hospital and community health services for patients. The main provisions of the Act came into force on April 1 1991 and have been the focus of much debate.

Nurse managers have been profoundly affected by these changes. The abolition of AHAs removed many career opportunities for nurses and the introduction of general management left them in an ambiguous position. Although some have gone into general management, many others have lost their line management role and have been excluded from management boards, becoming instead nursing 'advisors'. This, combined with an increasing tendency towards local management through Directly Managed Units (DMUs)s or NHS Hospital Trusts (HTs), has disrupted the whole

nursing management hierarchy. In some localities, remnants of the previous system remain. In others, ward sisters may be the most senior nurse in the hospital, with no clear reporting function through to national level. With the split between purchasing and providing in the 1990 Act, the DHAs and RHAs now have no clear role in nurse resource planning. It has been noted that 'there is much concern as to how nurses are to be equipped to take on the more senior jobs if there are fewer intermediate jobs in which they can gain skill and experience' (NAHAT,1991:175). More generally, these changes have entailed the disintegration of a relatively well-defined line of planning and reporting from national through to unit level for nursing resources, the main input into the NHS.

In the light of the above changes, the fieldwork research design requires some explanation. The intention was to evaluate changes in nursing and so experts in nursing management were sought. Early interviews were conducted with general, financial and personnel management and regional, district and unit nursing management, along with nurses involved at national or local level in nurse training. The district nurse managers proved, as anticipated in the original formulation of the fieldwork, to be a particularly rich source of information, particularly as all the managers interviewed were personally involved in the clinical regrading exercise from its inception. These interviews form the core of this chapter although other interviews have also informed its content.

The interviews at district level were based on a structured questionnaire and lasted between one and three hours. They were conducted in the year prior to the changes introduced in April 1991 in eight DHAs ranging from inner city, urban and rural areas. The DHAs were selected to include HAs which had plans to become Trusts, to introduce Project 2000 or to initiate National Vocational Qualifications (NVQs) and Health Care Assistants (HCAs). Otherwise, they were randomly chosen and an almost 100% response rate was achieved, thus avoiding the dangers of a substantial element of 'self selection' amongst participants. The nurse managers were all what

would previously have been denoted 'Chief Nursing Officers'. Their current and proposed roles were not uninteresting; some had veered towards an advisory role, sometimes on a contractual basis; others had been taken onto management boards at hospital or forthcoming Trust level; whilst some were left in a somewhat undefined and ambiguous capacity at district level. The majority of those interviewed were male, reflecting the disproportionate representation of men in the upper echelons of the nursing hierarchy. All were nurses, and all of them had at least twenty years of experience in NHS nursing, with some of them having considerably more. Their routes into nursing had been quite diverse and this was to prove an interesting link with other interviews on training and skills and attitudes to nurse resourcing.

NATIONAL DECISIONS ON RESOURCING NURSES

It was argued in Chapter 4 that defining demand and supply within the NHS is a far from precise exercise, much influenced by normative considerations and therefore subject to considerable controversy. If the economic jargon of demand and supply is hard to apply to the NHS in general, it is even more so for nurses. The inappropriately named 'nurse manpower planning' process and practice are affected by wider problems in defining the demand and resourcing the supply of healthcare, yet are also an integral part of such problems given the importance of the nursing input in the NHS. Particular aspects of these problems become apparent at different levels in the NHS and range from what might be considered strategic decision making at national level to the day-to-day problems of healthcare provision at ward or hospital level.

At the national level, decisions are made on the funding of healthcare against which background questions surrounding demand and supply are frequently subordinated. The measure of effective demand which emerges then plays an ambiguous role, being somewhat unresponsive to both changes in 'pure' demand, or healthcare needs, and supply conditions, whilst at the same time helping define them to a greater or lesser extent.

National decisions on funding the NHS emerge from a wide-ranging political and economic decision-making process on the economy and the role of public expenditure within it. The Public Expenditure Survey (PES) takes place each summer whereby the government reviews its expenditure plans for the next three years. The spending departments, including the Department of Health (DoH), put forward their own plans, which include a review of future efficiencies and service development, prepared jointly with the Treasury within guidelines approved by ministers earlier in the year. The PES is co-ordinated by the PES Committee (PESC), a group of interdepartmental officials chaired by the Treasury. After further discussion with the Treasury, spending plans are finalised in November in the Chancellor's Autumn Economic Statement. This is then published in more detail in January in the White Paper on Public Expenditure. The NHS is not directly involved in the PES - the DoH acts, in theory, as its representative. NHS management must therefore use informal routes if they are to influence the process.

The problems with this process have long been recognised. The disproportionate influence of the Treasury and de facto lack of representation of NHS managers means that service requirements may be subordinated to wider goals for the public sector and the economy. With respect to the disproportionate influence of government as a whole, political considerations can feed through very directly and at the expense of longer-run strategic service considerations. This is particularly pertinent for the electorally-sensitive NHS. The funding of effective demand which is produced by this system thus bears little relevance to healthcare needs at national or local level nor to the supply of healthcare, despite a recognition of the distinct and particular problems engaged by the latter (see Buchan in Robinson et al, 1992:38-51).

These problems have been exacerbated in recent years. It was noted in Chapter 2 that a form of more or less explicit cash limit has always existed for the NHS, and can be seen in the attempts at wage restraint that have characterised the history of the NHS. However, a subtle

shift in emphasis took place with the introduction of explicit cash limits in 1976. The importance of cash limits has to be understood in terms of both planning and control. Volume planning has never been a precise exercise in the NHS, partly because of the normative elements involved in defining the need for healthcare and partly because of its labour-intensive nature. As noted in Chapter One, wages account for nearly 80% of the RDSHA Net Revenue Expenditure (1991 figure calculated from HPSSS for England, 1992:15-27) so that the larger part of planning is concerned with pay. With nurses' pay accounting for over £5 billion and 36% of HA's Net Revenue Expenditure, peaking at 37% in 1989 following clinical grading (ibid), and their employment accounting for around 50% of all NHS directly employed staff (ibid:33), it could be expected that nursing employment and pay would be particularly important targets for planning policy.

The history of the NHS and nursing described in previous chapters does not lend much credence to the view that volume planning prior to 1976 was a careful and scientific process; such 'planning' was always intended as a form of implicit wage control. The shift from 'volume' planning, based on current pay levels, with supplementary votes, to a system focused more on anticipated pay levels and cash limits must therefore be understood in this light, and with all the subtlety this entails. Introduced at a time of very high inflation and increasing confidence and militancy on the part of NHS workers, the old system of implicit or explicit incomes policies and the less overt form of cash limit implied by volume planning simply did not work. Year on year planning became increasingly 'rough-tuned' with the need to make post-hoc adjustments for pay awards and, to some extent, for NHS price inflation for supplies. The 1974 Halsbury award was a crisis point in this respect. Cash limits could thus be viewed as an explicit attempt to enforce incomes policies and 'smooth' the planning process. In the period from 1976 to 1979, incomes policies and cash limits were intended to 'pincer' NHS pay to the extent that NHS workers were made to understand that the NHS would be more strongly resource-constrained and that their pay was an important factor in NHS resources.

This policy was taken several steps further from 1979, however, with the tightening of cash limits and the abandonment of explicit incomes policies. Planned cash limits were now to be viewed as being co-terminous with the 'outturn' for the NHS. The implication for NHS workers was that there would be an income-employment-service development trade-off, unless substantial 'efficiency' savings could be made. This policy was backed up by an explicit planned allowance for pay increases (or pay assumption), which featured strongly for most of the 1980's in the pay review process. The important changes in planning and control therefore lay in the gradual inclusion of an explicit pay increase assumption in expenditure plans and the suggestion that such plans were final. Volume plans on service expansion would therefore be subordinated to pay award outcomes or cost efficiency savings, with the government let 'off the hook' on both counts, particularly with the establishment of the Pay Review Body in 1982/3 and the increasing focus on 'general management'.

Winchester made some particularly important points about the early functioning of the new system for the public sector more generally (1983:173). Firstly, he suggested that cash limits would provide little indication of the details and possible consequences of pay policies, which would depend on other expenditure decisions and financial controls, and the government's attitude towards the avoidance or resolution of industrial conflict in particular sectors. This point has been amplified for nurses in the first part of the thesis, although it has also been shown that government has a number of tools at its disposal to skew pay outcomes towards its original cash limits. Secondly, he suggested that the impact of government pay restraint policies based on cash limits would depend more directly than formal incomes policies on the decisions and choices of public sector employers; 'the separation of national negotiations on pay and local discretion on manpower decisions presents obstacles to an effective income-employment trade-off in most public service negotiations'. It is this to separation and its effects, along with the influence of grading and training, that we now turn.

LOCAL DEMAND FOR NURSES

When spending plans have been finalised and cash limits decided, monies are allocated from the DoH to RHAs using a weighted capitation formula. This is then distributed to DHAs and units. However, where pay awards have exceeded the cash limits, cash limits have had to be subsequently revised to include funding for all or part of the excess over plan. This has re-introduced the element of 'rough-tuning' into NHS planning and created a degree of uncertainty over the future financial position of health authorities (see e.g. NAHAT, 1991:56). This uncertainty is likely to blight the progress of the split into purchaser and provider and the contractual form of the new NHS reforms, and has been further complicated by the introduction of capital charges. Quite apart from planning uncertainty, partial funding of the excess of pay awards over planned cash limits can cause particular problems since this means that budgets set for the current year at local level will automatically be overrun, unless savings can be made through cost improvement programmes (CIPs) or other 'efficiency' measures, or further income generated from additional sources. A final solution is to cut staff or services. These measures are, of course, entirely consistent with the ethos of cash limits, though it could be argued that the longer run intention is to put downward pressure on wage claims.

The first part of the fieldwork questionnaire was aimed at obtaining an understanding of the perspectives on the demand for nurses at local level. A very high degree of unanimity amongst nurse managers emerged from the interviews, though differences in emphasis were also evident. The majority of managers saw insufficient resources emanating from national decisions on funding as a primary constraint on local demand for nurses. This response was surprisingly constant across districts or units, despite managers' perceptions that funding was unequally allocated and much influenced by status (for example, flagship teaching hospitals) or local politics (such as the influence of local chairman in wider politics). Thus, although horse-trading could shunt some funds around, underfunding was seen as the more general problem.

The underfunding of pay awards at national level was widely seen to be exerting a considerable constraint on effective demand for nurses at local level whilst the national clinical grading exercise in particular had exerted an upward pressure on the nursing paybill. In 1992 some 38,000 appeals still remained to be heard and, in theory, regrades would be backdated to 1988, though management were attempting to 'buy-out' appeals and to avoid backdating (Nursing Times/Standard, 13th April 1992). Managers at regional and district level pointed out that the original grading exercise had been cash limited. DHA managers had been required to submit estimates for the exercise; after these and prior to the official exercise taking place at local level, the numbers of grades (with percentages for each) and grading definitions were imposed providing an effective cash limit on the process. One manager put it thus: 'The procedural arrangements were imposed by the government. No negotiation or consultation took place with the unions over these'. The original exercise produced quite mixed results from district to district; however, where the cost of clinical regrading given by the DoH was exceeded, the region withheld money. With regrades from appeals subsequently feeding through from 1988 to the present, such extra monies therefore usually represented both an excess over the original cash limit and an unplanned year on year excess which had to be found outside the normal annual pay award monies. Such excesses were then 'pincered' by the cash limits imposed at national level and applied down the NHS structure, reinforcing the government's explicit desire for cost efficiency improvements or income generation. The overall regional cost of clinical grading had thus exceeded the original 15% shown in the pay review process for 1988 by several percentage points and a final figure is still unknown.

Managers argued that quite apart from the direct costs of clinical grading, the exercise had also contained a number of hidden costs at all levels in the region (see also Burchill,Health Service Journal,1993). Firstly, a vast amount of management time had been involved in the original procedure and subsequent hearings and appeals. Numbers varied substantially by DHA, but it was not abnormal for over a thousand informal hearings to have taken place, with many

hundreds of appeals then going on to formal hearing at district level, a number of which remained to be heard at the time of interview. Relatively smaller numbers then went on to regional level but represented substantially harder cases to 'resolve', particularly as the system allowed for three managers and three trade union representatives to handle regional appeals. One manager suggested it would be unlikely that a decision would be reached at that level. It was pointed out by another that the changes in management at district level would mean fewer managers were available to hear cases and this in turn would further delay the process. Most managers felt that at least one year of their time had been almost completely absorbed in the regrading exercise; a most conservative estimate of the cost of the time taken up with the process at regional level would therefore run into millions of pounds. Secondly, the exercise had had an effect on staff in terms of recruitment and retention and morale, but this was rather harder to cost. It may be recalled that the stated intention of the exercise was to improve recruitment and retention by providing proper reward and career pathways for clinical nursing.

It was universally recognised by the managers that no clear measure of 'pure' or 'real' demand for nurses could be defined. Quite apart from the difficulty of measuring pure demand for healthcare in the district or locality (of which waiting lists are only one expression), the degree of 'dependency' of patients in treatment is variable by speciality and by individual response to treatment. The development of a wide range of 'dependency studies' in the late 1960's, which have been in increasing use in the 1980's along with regional staffing 'guidelines', were not seen as providing a finite measure of the necessary quantity, grade-mix or quality of nursing care. In particular, such 'guides' take little account of time spent talking to patients and caring for their psychological welfare - and the increasing medical acknowledgement of the curative effect of such activities. In these respects, the rather 'scientific' appearance of some of these systems was queried, with a number of the nurse managers appearing to regard them as having more to do with management fashion than with measuring demand or aiding forward planning.

However, despite these problems of definition and measurement, a picture of local demand for nurses began to emerge from the interviews which highlighted a conflict between the effective demand induced by national funding and pay decisions, and the 'real' pressures of local demand. Managers were clearly united on the emphasis in changes in the direction of real demand for nurses; these were invariably seen as being upward. Demographic change and technological advances in medical treatment were seen to have increased the demand for healthcare in the localities through an increasingly aged population and new possibilities for treatment. The resulting pressure on service development in turn increased the real demand for nurses. At the same time the work demands placed on existing nurses were seen to have increased. New medical treatments enabled faster throughput of patients and such throughput had also been influenced by political considerations, along with the desire to decrease waiting lists. A considerable amount of controversy surrounded the interpretation of faster throughput; it was suggested that on some occasions ill patients had been discharged too quickly, or discharged and then readmitted later, thus increasing throughput statistics. However, the net effect is that patients had tended to be more dependent whilst in hospital and thus to require a more intensive level of nursing care.

That technological change has tended to intensify the need for nurses provides a most unusual foil to the more general economic tendency towards labour-replacing technological change. The technology developed for intensive care units or neo-natal units were particularly highlighted by managers as increasing the demand for nurses and this was particularly true for 'flagship' or teaching hospitals with traditionally higher levels of technology. Computerised techniques for administrative purposes and recording of care were also largely seen as increasing the nursing workload. With a need for detailed costing in the new 'internal market', and the moves towards primary care implied by the Citizens' Charter, this workload is likely to increase. However, as one manager put it 'the development of technology has been uneven' and has reflected wider interests in the NHS at the expense of developing technologies to

assist in the care of the chronic sick or those currently needing labour-intensive nursing care.

None of the managers identified any 'automatic' change in demand with respect to different grade-mix implied by the changes in demography and technology. This was seen to have far more to do with planning and choice and the actual development of services; for example, whether these tend to treatment of the elderly or acute treatment, with different grade-mix implications.

Against this generally perceived increase in the real demand for nurses, the resource constraints on effective demand have had particularly pernicious effects. At the national level, resource decisions have usually been made on the basis of 'historically funded posts' on the inflation-level cash limit basis, with pay awards sometimes funded in full, but more often only partially. Some adjustment for service development is also made but this has more usually involved 'shunting' funds between regions, districts or units rather than increases per se, particularly when pay awards are underfunded. Resources at local level emerge as an uneasy compromise between a historical level of nurse resourcing and a 'new' service development level as tendered in plans by the DHA or unit, but many of the aspects of healthcare demand increase are simply not addressed. Staffing guidelines and dependency studies have become an increasingly important part of planning for some localities, but appear to have been largely motivated by a desire to contain cost at national and regional level. They have produced mixed results as nurses at ward level may use such instruments to argue for increased levels of nurse provision; thus some nurse managers expressed a preference for using 'professional judgement'.

What is asked for is naturally influenced by the 'bargaining' context and would tend in any case to be imprecise. One manager mentioned that 'if we receive 70% of what we have asked for, we feel we've done quite well'. Perceptions of underfunding thus occur in a context in which real demand for nurses is probably substantially underestimated.

Several managers made the point that their real problems have revolved around maintaining the historical level of posts, even discounting for service development. Cash limits have generally been based on inflation and national pay awards in the 1980's were often higher. Underfunding of pay awards can thus affect resourcing at the existing level of nurses quite apart from any normative or planned level. In one district, a manager commented that 'the underfunding of pay awards constrains the management board from developing services as fast as needed...we aim to protect the base'. Another manager suggested that:

Despite the growth in demand, our acute services were capped and it was difficult to maintain the level of nurses. The Finance Officer decides the nursing budget using an inflation measure. If pay awards mean this amount is exceeded and if the difference is not centrally funded, we have to use service development money.

Another manager put it more bluntly: 'If we're underfunded, it means a reduction in staff'. Yet another manager noted that:

When underfunding occurs, we look at skillmix, reduce the speed at which we replace staff and look at areas where reductions in staffing levels won't be felt. We tend to rely on natural wastage as redundancies are expensive - part of my job is to guess where these will occur.

This last point casts light on the complex causation behind shortages. Traditionally it has been assumed that shortages arise purely from an inability to attract staff to fill funded posts given low pay. Here the suggestion is that shortages also arise because of insufficient funding to offer enough posts at low pay. As became evident in the review process, if posts are subsequently cut from establishment, this actually obscures the shortages which might exist for either demand- or supply-side reasons - or both.

NATIONAL AND LOCAL INITIATIVES TO RESOLVE DEMAND DEFICIENCIES

Several national initiatives were launched in the 1980's and early 1990's designed to increase funding raised at local level. NAHAT suggests that 'resources released from improved Value For Money (VFM) have provided an important source of finance for service developments

and expansions, and pay and price rises which have exceeded the Government's cash limit provision...[and] will continue to be a significant source of finance in the future' (1991:64). NAHAT notes, however, that Cost Improvement Programmes (CIPs), which increased from a 0.2% contribution in 1981/2 to 0.5% in 1983/4, have hovered around 1% from 1984/5 and face an uncertain future. About a third of such savings were achieved through competitive tendering for domestic, catering and laundry contracts but 'such an extensive source of savings may have dried up'. Other sources, such as price reductions from improved contracts with suppliers and general reductions in labour costs 'may become the main sources of cash releasing programmes for the future...However, the cash savings may not be as large as in previous years, as health authorities have steadily improved their efficiency during the 1980's, making further savings not only more difficult to identify, but more difficult to achieve' (1991:65). It is interesting to note that CIPs are not intended to be achieved at the expense of the volume or quality of services and some of the 'improvements' involving labour have been highly contentious in this respect. Moreover, increased efficiency through increased throughput can actually create an increase in total expenditure as the costs of treating more patients rise, for example, through spending on drugs, and medical and surgical supplies.

Income Generation Schemes (IGSs) followed CIPs onto the management agenda. These IGSs have included selling surplus capacity to other agencies (spare laundry or cookchill capacity), maximising the commercial opportunities of the estate (letting accommodation to banks, newsagents, florists), direct appeals to the local community for cash (charity), or using new legal powers under the Health and Medicines Act 1988 providing for DHAs to raise income in the following ways:

- * acquire, produce, manufacture and supply goods
- * acquire land and manage and deal with land
- * supply accommodation
- * provide instruction
- * exploit and develop ideas
- * apply commercial charges.

Forecasts for income generation on this basis, with respect to the revenue account, were for £20m in 1988/89 and £80m for each year thereafter. With respect to the capital account considerably higher sums have been raised - and are expected from - capital receipts from sale of land and rationalisation of sites. However, once again there are limits. Initial forecasts of a 1% contribution at national level are not being realised and 0.5% is emerging as a more realistic rate. Although the depressed property market provides good purchasing opportunities it hinders the sale of NHS assets. A high degree of risk is involved. Additional capital finance needed to create the infrastructure to generate additional income is also lacking. Hence HAs finally appear to be relying more on growth in private patient income to increase their profits from income generation. In this respect, the NHS reforms have been seen as a fundamental means of extending the income generation approach which has:

moved from the margin of HCFS finance to the main thrust of resources. NHS trusts and DMUs have now to earn all their income from quasi-commercial or truly commercial contracts...increasingly commercial practices will be needed towards the mid-1990s as the NHS reforms gradually fall into place (NAHAT,1991:68-69).

Discussions with local managers broadly substantiated the types of venture attempted under CIPs or IGSs, albeit with some differences in emphasis. However, with respect to both CIPs and IGSs, most managers appeared to feel that these were something of a side issue, 'peripheral in terms of the paybill - unless we go in for selling healthcare' and of very limited value in raising effective demand for staff, and nurses in particular.

In the early 1990s for example, an average-to-large DHA might have a budget of £80 million, of which some £30 million would be consigned to the nursing budget/paybill [1]. A pay award for one year might therefore be measured in terms of several millions of pounds, and the difference between the cash limit 'inflation' or other allowance for pay increases and the actual settlement may again be over £1 million.

[1] DHAs' actual nursing budgets discussed in interviews varied 5% around the national average proportion of the revenue account.

The subsequent difference between additional funding [if] provided by the government and that which has to be found locally may therefore be very substantial indeed. For this notional DHA this could run into £100,000s simply to satisfy existing demand, with no service development. A Finance Officer suggested that a degree of 'creative' planning and accounting could help make some allowance for unfunded paybill excesses. However, this exercise had distinct limitations, particularly if year-on-year underfunding were to occur. He commented that the inflation rate was nearly always underestimated in national cash limits and that in any case top-up funding for excess pay awards was not paid for all staff groups. In his view, clinical grading had caused particular problems - between one and two per cent of the nursing paybill had had to be found locally.

With respect to CIPs, relatively little scope exists for cost savings on non-pay items such as equipment and supplies. The average national figure for non-pay items is only some 23% of HCCHS net revenue expenditure (average national figure - calculated from HPSSS 1990), and this figure overestimates the importance of these items as it includes a number of pay items such as indirect labour costs (for example, contracted maintenance or domestic staff). The shift in accounting procedure on ancillary staff on CCT contracts has artificially held down the total NHS paybill figure.

A District Finance Officer went through main expenditure items in interview. Drugs and medical equipment prices had been rising faster than inflation (see Doyal, 1979:191-194) and potential savings were limited by the medical profession, clinical judgement and by increased throughput as noted earlier. Much of the hi-tec equipment was imported from the USA and exchange rates were also a factor in cost fluctuations. Computing costs had also been increasing, particularly fuelled by the NHS reforms and need to start accounting for 'manpower' resources and items more closely for the internal market. Some savings had been effected by the substitution of duvets for bedding and linen, and in energy usage and costs, and 'a positive decision had

been made to hold back on engineering and building maintenance'. CIPs in this area were thus relatively limited.

Pay at just under 80% of RDSHA net revenue expenditure is a much more important target and has been taking a higher proportion of revenue throughout the 1980's nationally, with the nursing paybill being the largest element and one of those which rose the most markedly over this period. The District Finance Officer interviewed above saw underfunding of pay awards as the biggest problem. Despite attempting to make some allowances for this, his comment was that 'we can't manage for ever'.

The main thrust of CIPs has therefore been focused on labour costs. All the districts had gone through the competitive tendering process and many of the contracts had remained in-house, an exercise which, following a national initiative, was seen by one manager as being clearly intended as a 'means to reduce the pay of the lowest-paid staff'. The suggestion from NAHAT, above, is that around a third of CIP savings were made in this way. This figure was not substantiated at local level and there may have been local variations or inconsistencies in implementing CCT and in accounting for savings. In a couple of cases external contractors had gone bankrupt or attempted to renegotiate contracts. In others, contracts had reverted to in-house provision due to poor quality service provided by external contractors. Most managers expressed some satisfaction where in-house contracts had prevailed and the process of CCT did not appear to have been welcomed by many managers. In part, this may have been because of de facto overlaps in tasks between ancillary and nursing staff, and in part because of resultant problems with morale. Some managers appeared to regard the exercise as distasteful and carrying potential costs in terms of service quality. It was commented that services such as maintenance and non-urgent ambulance tasks were increasingly being targeted for external contracts, again following national-level initiatives.

Other forms of labour cost savings falling under the 'official' definition of CIPs had been attempted by managers. These had included attempts to effect savings by reducing the use of agency nurses and making increased use of own bank staff, reducing overtime payments, and changing shift patterns and overlaps. Most managers reported substantial savings from changes in shift patterns, although some industrial relations problems had arisen as a result; one manager reported that relations with trade unions became 'turbulent' after the changes had been effected although they were negotiated in advance. A medium-sized district had 'saved' 20 nurses through shift changes claiming these savings had then been used for service development. In theory, changes in shift patterns could also provide more flexibility for staff but the extent, for example, of overlaps remains much disputed, as does its effect on quality of service as overlaps provide time to 'handover' details on patients. The initiatives appeared to originate mainly at national level, passing down through RHA and DHA, as was also the case for so-called 'skillmix' changes.

Skillmix changes have now become a major focus for cost savings and a predominant focus for change and debate, particularly within nurse resourcing. These are worth noting because such attempts at cost reduction may or may not fall outside the scope of CIPs; if such changes are defined as changes in skillmix rather than in grade-mix or taskmix, the quality of services may be reduced.

There was huge local variation in the degree of skillmix exercises already conducted; some districts had done relatively little in this area, while others had conducted several reviews in the 1980's. Very mixed results had been achieved. In one case, a manager reported that 'no savings were made - we actually found we were underestablished and therefore asked the region for more nurses'. The finding of 'no savings' was also echoed by some other managers. Another manager reported that the systems for skillmix were not ideal, particularly as the real problem was 'too much work and not enough staff'; he had therefore preferred to negotiate over workload at ward level, but this had to be done within financial limits. A District Personnel Manager

mentioned that clinical grading had opened up the possibility for 'skills to be more precisely arranged', but this view was not shared by nursing managers. Every manager interviewed, however, expected skill mix changes to be forthcoming as part of the national initiatives on training and resourcing; in particular, those on HCAs and NVQs and on Project 2000. The impetus behind these changes appeared to have little basis at local level; none of the managers had identified changes in local demand as necessitating changes in skillmix and the majority had identified underfunding as the main problem. All appeared resigned to change but only a minority appeared to welcome it and with some very strong reservations. Overall, the interviews revealed relatively limited CIP savings at local level, and more importantly, even less potential for doing so in the future if the 'ethos' of non-reduction in service or quality was to be maintained.

Views on income generation were even more pessimistic. A number of the districts had introduced schemes for 'selling surplus capacity', such as cookchill. These schemes, however, had largely consisted of selling between hospitals rather than selling to external customers. One DHA reported that it had generated a large amount of income by selling to other HAs. However, another commented that some HAs had been 'frightened off by capital costs and listeria' and yet another that some HAs 'had got their fingers burned here'. One manager reported that his hospital had introduced charges for car parking at the hospital, receiving a lot of media attention and public disapprobation. Overall such schemes appeared to be regarded more as a way of rationalising services than of generating savings or income.

'Developing commercial opportunities for the estate' had also been tried in a number of districts, with lets to flower shops, solicitors' shops, maternity shops, newsagents, small cafes, and so on, but income from these sources was still seen as peripheral compared with the paybill and underfunding problem. Charitable ventures and Trust Funds had always been in existence in the NHS and, whilst such sources of additional finance were welcomed, these tended to be used only for additions to the capital account and new developments such as

buildings, wards or equipment. One manager commented that charity is deeply dependent on public preferences - 'children fare much better than the chronic sick and elderly'. Another described a hugely successful appeal for a new building of nearly two million pounds but pointed out that the HA had to transfer existing staff to the building and could 'only open up as many beds as these staff could be employed on; we will need extra funding to open up the others'. All the managers were dismissive of any possibilities for funding nurses directly either through charity or 'brand name' support by private companies, viewing this as ethically undesirable and as an inconsistent source of finance.

With respect to the increased commercialisation and local fund raising envisaged in the Health and Medicines Act 1988, none of the district or unit managers felt that the orthodox source of local funding (that is CIPs and IGSs) had provided sufficient funding for shortfalls or that they could do so in the future, unless local private healthcare services could be developed and exploited to the full. All the HAs had experienced restructuring and rationalisation through the 1980's; in one case the number of hospitals had been more than halved. Throughout the 1980s the NHS capital account was buoyed up by land sales, initially encouraged by national level strategic decisions and now by capital charging. However, managers were sceptical about future additions to capital from land sales, noting once again difficulties with the current state of the property market and the inconsistency of this source of income for revenue expenditure.

The greater effect of such rationalisation had been to reduce in some HAs the need for nurses through hospital closures, particularly of mental hospitals, and to induce a tendency towards new and larger hospitals. Nurses could then be redirected, aiding the 'solution' of shortage problems, or 'natural wastage' could be allowed to occur, releasing resources for nurses in other hospitals. In the case of mental hospitals, pending any large input of resources into Community Care, this represents a real service reduction. Several managers mentioned that rationalisation had also included the closure or

relocation of long-stay geriatric facilities. The 'burden' of provision had thus been passed to the private sector, local authorities or, more generally, back into the 'community' through care by relatives. In one case, a manager reported that the closure of a long-stay ward had been compensated for by contracting beds in private facilities. The numbers of beds contracted were less than a fifth of the original numbers however, although the manager viewed the arrangement as being better than possible alternatives and providing better facilities. Another manager mentioned that where the private sector was undertaking more long-stay care, staff were being poached. The national figures on mental and geriatric beds broadly substantiate these local changes (see HPSSS 1990) but have tended to get rather lost in the argument that greater throughput requires fewer beds. In the case of geriatrics, such throughput generally does not pertain in the same way as for acute care. A number of managers also mentioned the 'temporary' closure or part-closure of wards together with the 'freezing' of nurse vacancies as a means to reducing demand for nurses. It will be apparent that such measures reduce service provision.

Managers had therefore 'managed' resource constraints arising primarily from underfunding largely through measures which can only be termed service reductions, stemming either from national strategic decisions on site rationalisation or local reactive decisions to shortages of finance. The movement to the community of the elderly and the mentally ill must also, therefore, be understood in the light of resource constraints; this underlines the point made in Chapter Two that nursing should be more widely construed to include nursing care undertaken at home.

LOCAL SUPPLY OF NURSES

It was noted in the discussion of the pay review process in Chapter Four that much current debate has centred around the existence, or otherwise, of nursing shortages and projections for the future based on demographic trends. Before going on to explore the fieldwork

results on nursing supply, a note of caution should be attached. Firstly, many of the issues arising under 'supply' are highly sensitive, not least because of the importance attached to them in the pay review process and local politics. The questionnaire was therefore devised in a manner which presented key questions in several different ways, and contradictory answers were occasionally given. Secondly, the interviews took place in what might be regarded as extreme macroeconomic conditions - a severe recession following a decade of high levels of unemployment.

Despite high levels of local and national unemployment, nurse shortages were reported by the majority of managers in interviews, although the extent and type of shortages were highly variable. The questionnaire sought information on both these facets of nursing shortages as well as data which would help establish the source of sample variation, since this would carry implications for possible solutions. Questions on the local labour market were also asked.

The response from most managers was that local housing stocks, the mobility of nurses, and local labour market conditions were important factors in recruitment and retention. However, such local conditions were seen to interact with wider national factors, such as unemployment and housing more generally, the numbers and types of nurses being trained and the draw on nursing staff from the growth in the private health sector. Recruitment and retention was highly variable by type of hospital. For example, prestigious teaching hospitals attracted recruits more easily but nurses trained there were more likely to leave for other areas. It was also highly variable by location in urban, semi-urban or rural areas; inner city DHAs and unit managers faced particular problems. There were substantial differences by all these factors between qualified and unqualified staff, and married and single staff.

The majority of managers reported shortages of specialised qualified nurses, particularly in hi-tec specialties such as intensive care, theatres and paediatrics, and in midwifery. Post-RGN training numbers

and funding were seen by some as insufficient and the private sector had poached trained staff in these areas as in many others. With regard to recruiting for own training or trained staff, mental and geriatric nurses also presented difficulties for some managers. It was reported that wastage was high during training; national figures show this clearly and regional managers confirmed that highly qualified nurses were being lost to the profession. After training, wastage occurred when husbands were relocated in their jobs or when nurses became pregnant. One manager summed up the DHA's experience in recruiting nurses for training as follows: 'the real problem lies in financing them'; although numbers for teaching hospitals were set at national level, nurses were traditionally recruited and funded for training locally. Chapter Two has noted that training numbers have declined substantially.

Managers were particularly anxious about the future effects of national initiatives on training such as Project 2000 and the decline of the EN role. Turnover figures varied widely between DHAs, from between 7% and 30%, with higher turnover for qualified staff. The majority of managers reported few difficulties in either recruiting or retaining unqualified staff, with several managers actually recording 'queues' for unqualified staff vacancies. However, in this respect, urban areas were slightly more likely to experience problems.

It was clear from the interviews that the majority of managers believed that problems in recruitment and retention had been temporarily eased and superceded by the recession in general and by issues on the demand side - in particular, by resource constraints. In this respect, and despite complex local variation, the broader problem was not how to train, recruit and retain nurses but how to pay for them in the first place. The point was thrown into sharp focus by responses to a question on changes in nurse numbers. In two DHAs these had actually decreased in recent years. In others they had only held level despite increases in service demands. The trend nationally has been a decline in the rate of employment of nurses at the end of the 1980's. Under these circumstances, 'solutions' to supply

deficiencies were perceived by managers to be of a lower order of importance than 'solutions' to deficiencies in funding and demand. However, questions focused on such solutions raised some interesting issues about the interconnections between the two.

NATIONAL AND LOCAL INITIATIVES TO RESOLVE SUPPLY DEFICIENCIES

Managers were fairly reticent when asked about nurses' pay. Most reported their view that pay was not a particularly important issue in supply deficiencies, despite the evidence of surveys quoted in Chapter Four. The regional average pay for nurses was just over £9,700 after allowing for 15% overheads, and this kind of average labour cost might appear very attractive to a comparable private employer, particularly in male-dominated industries. Several managers were enthusiastic about the possibility of recruiting more men into nursing, whilst pointing out that personally they had been unable to manage on what was intended as a 'single female's' salary, and had sought early promotion into management. One manager noted that 'male nurses could be on grade 'G' by their mid-twenties' and that 'there should be a national drive...the image is more of a problem than the salary' [for men]. Another manager suggested that grades A, B and C were low-paid (this would cover 28% of all nursing staff), and that 'we can leave students out, as they are going on to the bursary system' (another 12-14% - so that according to this manager some 40% of staff's pay is problematic). A couple of managers suggested that nurses would leave to obtain higher grades elsewhere, whilst suggesting also that pay levels were sufficient. This was again potentially contradictory; higher grades do, of course, carry higher pay rates with them, even if status is also a factor. Another manager suggested that staff left more because of pressure and lack of job satisfaction. One manager noted increasing competition from the private sector for nursing auxiliaries.

These somewhat contradictory views on the importance of pay were further highlighted in responses to questions on childcare facilities and clinical grading. Before turning to other supply issues, it is

perhaps important to note one pay solution in which managers expressed no interest, namely, that of local or reduced pay. There was no evidence to suggest that these experienced managers formed any groundswell of opinion that pay rates were too high or that they should in some way reflect local labour market wages more closely. If anything, a number felt that demographic trends and the growth in private healthcare suggested increasing competition from other sources for their traditional supply of labour.

Several managers at regional, district and unit level mentioned local pay bargaining but did so with great scepticism. One manager commented: 'we would need industrial relations skills - no management would want to take this on yet'. Another suggested that 'local pay would just lead to poaching - nothing concrete as yet but the Chairman's quite keen to get rid of Whitley'. Potential poaching was also mentioned by other managers. One manager stressed that local pay was likely to be used by managers to increase pay to obtain specialist staff and that urban areas in particular would be likely to want to pay over the odds to attract staff. A *District Personnel Officer* mentioned that local pay seemed inevitable for HCAs and that if local pay were to come in more generally, the HAs 'would need to band together...or there will be a ratchet effect. We don't really have much negotiating experience - nor do the unions'. The fullest view was given by a manager in an HA which was just becoming an NHS Hospital Trust:

We would expect a system where inflation was met at national level and then any excess pay awards were negotiated locally. However, this would still be dependent on the budget provision and cash limits. In theory, this could be advantageous. In practice, we would need a consortium or there would be pay explosions and poaching. A lot of industrial relations changes are entailed.

Performance-related pay was not seen by the majority of the managers as offering any solution to supply deficiencies. Many managers were deeply opposed to the idea: 'No! I don't see any need for it for managers, either', 'No! Nursing is a team effort. It's hard to evaluate performance, especially in low-tec areas. Too many things

are out of nurses' control', 'maybe for managers but nursing is teamwork - how can you measure direct patient care?', 'No! Even for general managers. Short term objectives are promoted and it's especially stupid with cash limits'. A couple of managers were cautiously optimistic about the use of performance related pay for clinical ward managers, but said it would need much more thought for grades below that. One manager noted that the ethos of performance-related pay was fine 'if operated in a totally fair and unbridled manner' and joked that some General Managers had been 'very disgruntled' with their own performance pay!.

It has been noted in this chapter that the clinical grading exercise within a cash-limited system put particular strains on already constrained resources. One of the stated aims of regrading was to improve supply deficiencies through better rewards, more flexibility and a better clinical career path. Managers were thus asked whether the new grading system had provided an incentive for potential recruits, an incentive to stay or adequate promotion. This produced a veritable flood of responses. The broad answer to each question from the great majority of managers was 'no', particularly for unqualified staff. However, the individual responses provided a variety of reasons why this should be so, including some statements which contradicted earlier responses on the adequacy of pay.

Taking promotion possibilities first, these were perceived to be largely dependent upon wider funding constraints and also upon national decisions on the role of nurses in management. As noted in the introduction, many nurse management roles have evaporated. At lower levels in the hierarchy, promotion is resource constrained - depending on service development. Managers pointed out that in their areas there would be a long wait for promotion to sister, for example, and that only the more mobile nurses could move to obtain promotion. Clinical grading did not create more posts, and movement to higher grades (i.e. pay without promotional shift) was largely impossible as the grading exercise had been conducted in such a way as to reflect

the job rather than the person doing it, despite early rhetoric and expectations. Movement to higher grades was in any case cash limited.

Clinical grading is thus best viewed as change at the margins as far as supply deficiencies are concerned rather than as offering a fundamentally extended career ladder. Although clinical grades were extended, this affected a tiny minority of nursing staff. At the lower end where most nurses are congregated, there was relatively little change. As one manager put it: 'there are not enough grades in the system itself'. The effects on recruitment as far as pay and promotional prospects were concerned were also adjudged by the majority of managers to have been nil or negligible, with only a couple of qualified 'yes's'. The qualifications made pertained to the potential for managers to 'buy' grades but this evidently entails a loss of budgetary control.

The effects of pay increases arising from clinical regrading on retention, were again adjudged by managers to have been nil, negligible or, in some cases, to have been detrimental. One manager gave a qualified 'yes', with the qualification being that improved retention would cause incremental drift. A comment at regional level was that 'clinical grading never achieved from a management perspective what it was supposed to, especially with respect to the retention of good staff'. A manager of a prestigious teaching hospital, who was otherwise quite proud of how the exercise had been handled locally ('despite the appeals, people felt it was undertaken fairly') was scathing about the more general way in which clinical grading had been handled at regional and national level: 'the definitions were inadequate in the first place, there was no initial consultation...the exercise was handled very ineptly'. This manager felt that the success of the exercise would now depend upon how well competencies were set for each grade, a view echoed by a number of other managers.

Most managers felt they had handled the exercise locally as fairly as the national guidelines allowed but, as one put it 'the unions might

say otherwise'. All had to work within defined constraints, not the least of which was their own budget. Most managers now saw the need to develop advice on career development and to work out career steps from grade to grade. A number of managers clearly felt that the exercise may have had some detrimental effects, particularly on staff morale which would feed through into lowered retention: 'the exercise has been seen as divisive...morale is not at its highest'. One manager noted that 'it was a good idea, but it should have been implemented with more sense'.

A number of managers reported that staff and management had deviated substantially on definitions of 'continuing responsibility' and 'supervision' - 'we probably never will agree on them...even if national definitions were changed there would be funding problems especially over back pay...the aims of clinical grading were never realised...this has caused terrible upheaval...nursing auxiliaries expected much more out of it than they got'. A manager particularly concerned with midwifery staff said 'it was a mess...I don't see the point of it all. The NAs were all put on the A grade. There were very bad relations for a while - clinical grading was set up for nurses and didn't fit midwives'. Yet another referred to the 'trauma of clinical grading...there was no reward for service, only for the job itself. People misunderstood that. It was hardest for NAs, the vast majority were put on grade A and, unlike RGNs, they have no structure to go up'. One manager pointed out that 'clinical grading didn't really affect retention nationally'. Another manager felt that clinical grading 'acted as a disincentive...regrading shouldn't have been mixed up with a pay award'. 'Bad feelings and friction' had also been experienced through decisions over wards where there were previously two Sisters. Some managers felt it would be hard in any case to accredit improvements [if any] in retention to clinical grading: 'our general feeling that there is less turnover at the moment doesn't necessarily arise from clinical grading...it's more likely that staff may not be as mobile as before because of the state of the economy'.

Questions were also asked about 'non-pay' measures which had received popular exposure in the pay review process and to which the management side had committed itself at national level. Managers' views on the appropriateness of childcare facilities to aid supply deficiencies reflected problems with both funds and pay. Several managers were highly sceptical about the potential for such facilities: 'these are things for society to change', 'they're not cost effective but the unions want them', 'creches are too expensive for nurses', 'nurses are better off staying at home, at least with the first child', 'there's no demand yet', 'we don't have any at the moment - staff would sooner make their own arrangements and tend to sort these out in advance of job hunting', 'the problem is 24-hour coverage needed from nursing staff - against this, creches will always be too expensive'.

Against these views, some managers appeared more pro-active on childcare and this might be more understandable in the light of a huge national drive on this issue. However, these managers also pointed out the relative expense of their childcare facilities to nurses, even where the district or unit had succeeded in passing on the majority of costs of running such facilities to independent or voluntary providers (although space was often provided with some degree of implicit subsidy). The district with the best facilities in the survey provided some 70 places for over 3,000 nurses. None of the other districts came anywhere near this number and some had no facilities. Most managers thought the use of bank and agency nurses and moves towards more flexible hours were potentially more successful measures.

All the managers saw a need to attract mature leavers back into the profession. Such people were regarded as 'very stable and motivated'. A steady trickle of mature leavers return on bank or agency work arrangements and a couple of districts had been very pro-active in running 'come back to nursing' courses or searching for such staff. However, the general view was that these measures were unlikely to attract sufficient numbers of returners. Mature women were in general regarded as highly desirable recruits - one district had made particular attempts to attract mature women into nurse training, with

quite some degree of success. Mature women were also seen as desirable for future HCA and NA roles, although there was much uncertainty over whether such women would be available given demographic trends and competition for this type of labour.

Managers had all attempted to recruit from outside their own unit, district, or region and many advertised nationally, with varying degrees of success. However, for some specialities in particular, the result was clearly to shunt shortages around the country, rendering longer-term local training plans uncertain. Although some movement is inevitable and desirable, the longer-term implications are much the same as those which have pertained with private sector training and poaching in the economy more generally - a skills shortage.

CONCLUSIONS

The more general point that nursing demand and supply cannot be considered 'in isolation' from each other or 'from the effects of other factors relating to wider policy considerations and funding availability' has been well made elsewhere (Buchan in Robinson et al, 1992:47). However, the categories in this chapter, albeit mechanistic, have enabled a picture to be built up of the particular way in which national decisions on funding and NHS policy impact on local management, as well as to view the particular concerns of local management with respect to nursing supply and demand. Whilst the results are necessarily tentative, there is no reason to suppose that they are unrepresentative of managerial perspectives in nursing more generally, allowing for regional variation on supply shortages in particular. Results were checked against national trends, particular through DoH statistics and national health authority reports to see if any particular deviations occurred, and no substantial differences were found where there were comparable statistics or areas of discussion. There were broad areas of agreement amongst a sample which, as far as possible, was randomly chosen, and to which a nearly 100% response rate was received, thereby reducing the likelihood of self-selection.

The main findings were that managers appeared to feel that the stricter application of national cash limits and underfunding of pay awards had imposed resource problems at local level which had largely subordinated wider questions of demand for nurses or supply-side problems. In a highly labour-intensive industry the potential for non-labour savings or income generation was viewed as relatively restricted. Pay, grading, training, work organisation and employment levels therefore came into particular prominence.

With respect to the links between national pay decisions and local manpower decisions, there was little evidence from the managers that national pay awards for nurses were a problem; nursing pay was not regarded by them as 'too high' and national pay awards allowed them more time to manage. The clinical grading exercise provided the first example in the history of the NHS of a form of 'local pay determination'. The majority of managers interviewed had been personally responsible for the time-consuming exercise locally. Their experiences were on the whole not particularly positive and some were explicitly negative. There was little evidence from managers with a lifetime's experience of nursing of a demand for local pay determination - many regarded this as highly problematic from an industrial relations viewpoint (see also Seifert, 1990:54), and because of the uncertainty of the results which might ensue in terms of pay and potential skill shortages.

The way in which awards were funded and implemented was of more concern to managers. In these respects, the main problem for the managers was not their exclusion from the pay process and the potential for explicit income-employment trade-offs, but rather how to provide an effective nursing workforce against wider resource constraints which feed through in unpredictable ways and promote short-termism and reactive employment policy. This problem had become particularly acute after clinical grading and the tightened resource constraints of the latter part of the 1980's, and managers had come under increasing pressure to make adjustments in employment due to limited scope for savings elsewhere. 'Local manpower decisions' were,

however, seen to be again more limited than might be expected and driven by national policy. In particular, hospital restructuring and changes in the provision of elderly and mental health services had occurred. Changes in shifts and a more general intensification of nursing workloads could only proceed so far. It has been seen that nurse employment levels, against a variety of measures of pure demand, must be considered to have been a casualty, with the effects remaining to be fully felt, particularly in terms of the decline in service provision.

The main alternative to reductions in nurse employment were seen as more radical skill- or grade-mix solutions, again driven by national policy and raising questions concerning the quality and quantity of future healthcare provision. New national training initiatives were seen as an integral part of the changes, combining with funding constraints to impose the need for changes in grade-mix. Such changes would act to change the structure of demand, but could also be seen as being, in part, a response to supply problems. All the managers expected radical changes in grade-mix in the near future, failing radical changes in funding. These changes were envisaged to lead to a smaller core of trained nurses and a larger periphery of untrained nurses. The important reasons for this and implications are examined in the next chapter, which reviews the issue of grade-mix changes, training and wider healthcare resourcing in more detail and explores their interconnections with changes in provision of services and pay determination.

CHAPTER SEVEN

RESHAPING THE WORKFORCE?

This chapter reviews the issues 'underlying' the wage determination process which are seen to be critical from the perspective of local management. These concern employment levels, training, skills and grading, in the wider context of healthcare funding and provision. The analysis proceeds from a focus on grade-mix changes in the 1980s to recent change and dilemmas in 'reshaping the workforce' in the 1990s. This focus highlights the interlinkages between the issues and explores causation in grade-mix. It is argued that the role of local managers and of trade unions in particular needs to be taken into account. There is a high degree of uncertainty in cost minimisation strategies based on grade-mix changes, which is located in the conflicting perspectives on nursing work and the nursing workforce and a lack of understanding at policy level of the effects of grade-mix changes on wages.

GRADE-MIX IN THE 1980s

It will be recalled from Chapter Two that the early history of NHS nursing employment was characterised by a general expansion in line with the growth of healthcare, a long-term decline in training, and an ongoing process of grade dilution. Partly due to grade-mix decisions in the expanding 'cinderella' services and partly due to wider nationally-led cost containment initiatives throughout the service, the dilution was enabled by changes in training (ENs) and grade recognition (NAs) and the use of overseas and part-time labour. Thus, despite the Salmon Committee's 1966 elongation of the managerial hierarchy in nursing and the granting in 1974 to the most senior nurse managers of equal status with doctors and administrators in planning the health service, the period could reasonably be described as exhibiting few gains for the 'professionalisers'. Far from closing the profession, nursing appeared to be increasingly diluted from

below. It was argued that the changing composition of the nursing workforce was a major stimulus to the growth of membership and influence of the TUC-trade unions which were, in turn, able to militate for higher pay and to influence the professional associations in their own approach to pay.

This led in the early 1980's to what may well have been viewed by a government committed to rolling back the state, reducing the power of unions and with a much wider agenda, as a potential crisis in an electorally sensitive area at a time of great unpopularity for the government itself. If part of the solution was seen to be the Pay Review Body, it has been suggested that this did not remove the material basis for conflict and has been accompanied by a growing ambivalence on the part of government towards levels and methods of pay determination. The drive to pay decentralisation gathered pace in the latter part of the 1980's, as did the severity of resource constraints felt by local management as a result of underfunding of pay awards. This has led in turn to a re-consideration of changes in grade-mix at both national and local level.

Historically, therefore, there has been an interplay and tension between cost minimisation and constraint strategies based on wage settlements or mix of staff. It is in now turning in more detail to the 'non-pay' aspects of nursing employment that the contradictions within and between these strategies can be more clearly identified.

Grade Enrichment

After several decades of grade dilution, grade enrichment appeared to occur in the 1980s and, if this passed with relatively little comment, it also remains relatively unexplained. On the surface, this appeared to mark a sharp break with the past.

Grade-mix refers to the differential proportions of grades of staff in the overall nursing workforce. The interest in grade-mix which was expressed in all the fieldwork interviews, however, stems from its

much wider significance. Firstly, enlarging the relative proportions of lower grades employed is a way of attempting to reduce the overall wages bill, or as has been demonstrated of attempting to contain cost at a time of expansion. It therefore forms a primary cost minimisation or containment strategy in its own right. Secondly, grade-mix tends to subsume assumptions about the skill-mix of a workforce. For example, a 'richer' grade-mix might be regarded as a 'more skilled' workforce and be expected to produce a greater quantity and/or quality of work. Most of the debate around grade-mix change has focused on the validity or otherwise of this second effect. Grade-mix, skill-mix and skill substitution or dilution are, in fact, distinct conceptual issues (see Buchan and Ball, 1991:28). However, the interlinkages are such that debates on grade-mix draw out the deeper debates on skills valuation and usage. The emphasis of interest in this effect has rather tended to detract from some important contradictions with the first effect on the wages bill and this chapter corrects for this. Interest has also tended to focus on 'qualified' versus 'unqualified' staff proportions; here it is suggested that it is fruitful to disaggregate registered and enrolled nurses and learners and nursing auxiliaries.

TABLE 7.1 GRADE-MIX CHANGES IN THE 1980s

Year	% Qualified (of which)			Learners	Unqualified
		RGN	EN		
1982	55	39	16	21	24
1990	62	46	16 [1]	14	24

[1] The 1990 figures for RGN and EN split are estimates. In 1982, ENs accounted for 16% of total nursing & midwifery staff, with other qualified nurses accounting for some 39%. ENs cannot be separately identified after clinical grading, but from other (HPSSS 1990) figures they remained roughly constant. Thereafter, a number of ENs appear to have been subsumed under RGN statistics due to inadequate methods of data collection (interviews and HPSSS 1992 tables and notes).

Source: Calculated from PRB reports (various years)

Looking at employment by qualification for the 1980's as a whole, Table 7.1 shows that a change appeared to take place from 55:45 in 1982 to 62:38 in 1990. The precise measurement of this change depends greatly upon which health service statistics are used and, for the sake of consistency, the following grade-mix have been calculated from nursing statistics contained in each of the PRB Reports. Interviews with local managers also showed a split of roughly 60:40 for their overall nursing workforces at the end of this period.

Whilst the magnitude of change may not seem remarkable, the direction of change certainly is. Although it could be read as representing a more 'professional' workforce, it also represents a more expensive mix of staff in the 1980s than in previous decades which would seem at first glance quite inconsistent with government initiatives on cost efficiency and current policy proposals on skill-mix. Whilst this might form a powerful explanation for subsequent policy proposals, the question is begged as to how such a situation arose. At this level of aggregation, the figures show a decrease in training matched by an increase in RGNs but this does not explain the change. Such an explanation requires a wider-ranging analysis of other changes taking place in nursing employment over the 1980s.

Employment Levels and Healthcare Provision

Looking firstly at the evidence on healthcare provision in the 1980's in more detail, fairly conservative measures of increasing demand for healthcare in HCHS through demographic pressure, technological change and DoH priorities were generally viewed as being some 2% per annum (see RHSG,1987:46 noting the DHSS's acceptance of this figure in 1986, also Maynard & Bosanquet, 1986). From Table 7.2 it can be seen that public health expenditure, however, stagnated then declined as a measure of GNP in the 1980s. Although this ratio fluctuates with changes in output, it can be seen that there has been no great uplift in health expenditure. Using similar measures, Harrison et al. have argued that, even taking CIPs into account, the 'available evidence suggests that, during the 1980's, expenditure on the NHS has not kept

TABLE 7.2 NATIONAL PUBLIC HEALTH EXPENDITURE
AS A % OF GNP (market prices)

1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
5.0	5.2	5.0	5.2	5.1	5.0	5.0	4.9	4.8	4.9

Source: Calculations from CSO Blue Book 1990

pace with increased demand' (1990:37, see also Social Services Committee 1988).

These figures are reflected in nursing employment levels. Figures on nursing employment are politically sensitive and there is, partly due to this sensitivity and partly due to default, a notorious dearth of timely, consistent and disaggregated NHS data (see RHSG, 1987:pp36-71 on data problems). Series compiled from 1980 and which do not correct for the change in hours from 40 to 37½ which occurred as part of the Clegg settlement can overstate nurse employment by as much as 5%. Series from different data sources also give different results (see, for example, tables in NAHAT, 1991:158, 225).

TABLE 7.3 WTE NUMBERS OF NURSING STAFF IN GREAT BRITAIN

1982	482,000
1983	483,000
1984	482,000
1985	486,000
1986	487,000
1987	489,000
1989	490,700 m
1989	490,500
1990	485,000 [1]
1991	483,500

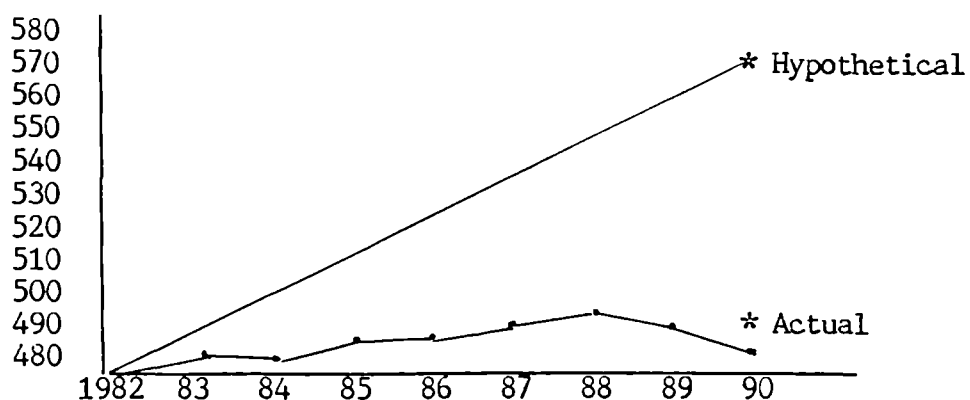
m = figure for March, all others are September

[1] Some categories of nurses were excluded in 1990 (PRB 1992:23), but the general decrease is not invalidated.

Source: compiled from PRB Reports, 1984-1993

A more representative characterisation of whole time equivalent (WTE) nurse employment levels in the 1980's is shown in Table 7.3. This uses a relatively consistent and uncontroversial series drawn instead from the Pay Review Body reports and starting from base year 1982 to avoid the problems of changes in hours [1]. The virtual stagnation of nursing employment during the 1980's as a whole and the decline at the end of the decade is clearly visible here. For interest, the most recent data for the early 1990s is also shown and it can be seen that the speed of absolute decline in employment has increased sharply. The above figures represent an increase in total nursing and midwifery staff between 1982 and 1990 of only 0.6% or around 1% at best allowing for data inconsistencies (see also Buchan and Ball, 1991:2 who arrive at a similar figure). Even taking the peak number in March 1989, an average increase of only 0.2% per annum for the period would apply. Figure 7.1 plots these movements against the hypothetical number of nurses that would have been employed had an average 2% increase per annum been achieved, on the assumption that demand for nurses rose in line with demand for healthcare provision.

FIGURE 7.1 HYPOTHETICAL DEMAND VERSUS ACTUAL NURSING EMPLOYMENT



Source: Calculated from PRB reports and estimated cumulative increase in demand.

[1] This series is fairly consistent with HPSSS 1990-1992 and Management Side Evidence for the 1991 and 1992 reviews.

The assumption that the demand for nurses rises in line with the demand for healthcare provision is a contentious one. The intermediate area in Figure 7.1 , or 'gap' between an actual peak increase of 9,000 nurses and a hypothetical pure demand for an increase of 82,500 nurses, may partly have been narrowed through use of other staff groups, changes in medical techniques, or increases in nursing productivity/work intensity (for example, through an overall rise in skill level, changes in work organisation increasing efficiency, or simply harder work or informal increases in hours). 'Met demand' has certainly been higher than the stagnation of nursing employment would imply, with increasing numbers of outpatients, day patients and other patients being treated each year (Buchan & Ball, 1991:2; Buchan 1992, Nursing Times v88 n4). Although it is almost certain that 'purer' measures of demand have not been met, the debate then extends to how close 'met' demand has come to the purer measure through productivity increase. Data is evidently not available for precise measures of this effect. However, the fieldwork and aggregate data is suggestive.

Firstly, there is little evidence to suggest that demand for patient care has been met by other staff groups. Nurses provide 80% of direct patient care and, if anything, interviews with nurses and managers suggested that extra pressures were accruing. There have been some increases in other staff groups over the 1980s, mainly in professional and technical and administrative and clerical staff (NAHAT,1991:especially pp225). However, figures showing the percentage increases in employment numbers of these groups usually overstate their importance in aggregate employment terms; nurses account for over 50% of the HCWS workforce, and these groups could only have had a marginal effect on increases in activity, particularly as rises in activity also increase the demand for other staff groups. The interviews in fact suggested that extra pressures were accruing to nurses from other staff groups. In particular, the overlap between medical work and nursing work, and between ancillary work and nursing work has been historically fluid and an important factor in the 1980s. Changes in technology and in doctors' hours, along with the drive to 'nurse-practitioners', mean that nurses have increasingly taken over

tasks which previously would have been designated for doctors. The recent decrease in ancillary workers (even allowing for contracting-out) has put additional pressures on nurses to undertake cleaning and other 'domestic' tasks. Nurses also claimed that considerable additional administrative burdens had been placed on them in the 1980s, partly as a result of the managerial and NHS reforms, and this had placed additional pressure on time available for direct patient care.

However, on the evidence of fieldwork and aggregate data, the 'gap' also cannot be considered to have been made up through work intensification or 'skill-mix' changes. Work intensification has undoubtedly occurred and can be seen not only in the PRB's acknowledgement of increased workloads for nurses but also in the findings from recent studies. For example, in their profile of qualified nurses, with responses from more than 3,000 nurses, Seccombe and Ball found that 'in the main, nurses were dissatisfied with the workloads they were confronted with, and the majority felt the staffing levels were inadequate' (1992:96). The same study found that 'almost three quarters of the sample agreed that working in excess of normal hours was an inevitable part of their jobs' (ibid). An earlier survey by Buchan and Seccombe found that 'the largest clinical groups - sister/charge nurse, staff nurse and enrolled nurse - reported average excess hours of between five and seven hours per week' with staff shortages and peaks in workload being the two most commonly cited reasons (Nurses Work and Worth,:vii). Much of this overtime is unpaid. Skill-mix changes were also seen in the grade enrichment, but is offset to some extent by that fact that technological change works to increase the demand for qualified nurses in particular. However, more generally, increases in activity, whether from advances in medical technique or faster throughput for other reasons, have also increased the demand for nurses through raised dependency levels whilst patients are in hospital.

The fieldwork in fact suggested that the increases in demands on nurses have almost certainly tended to counter the effects of

productivity increase and have produced a spiralling year on year pressure on nursing staff - and on the ability to meet demand. There is an obvious physical limit to extensions to the working day and intensification of work and the productivity increases that could be achieved in this way are thus limited. These pressures provide some indication of the degree of crisis perceived by managers in interviews, particularly at the point of an absolute downturn in nurse employment levels, and are particularly worrying as the exercise conducted here says little about 'quality' of care. As the health authorities have noted 'staff shortages and an increasing workload impose great strain on the nurse' (NAHAT, 1991:174), but this rather underestimates the significance of this for the provision of healthcare. Quite apart from quality, such pressures in the late 1980s meant that most managers and nurses felt that the gap between 'pure' demand and 'met' demand was actually widening. Thus, failing increases in nurse numbers, pressures would continue to fall on met demand through service reductions or pressures for grade-mix changes.

The above account of the extent of resource squeeze provides some measure of the impetus for change in the early 1990s. However, there are further influences in causation in grade-mix changes. Less aggregated employment data by qualification and full-time/part-time distinction is also useful in distinguishing between nursing staff fluctuations and aggregate levels. Losses, particularly in 1983, when the government ordered HAS to make reductions of staff (RHSG,1987:54), and in the latter part of the 1980's, were concentrated on nursing auxiliaries with losses mainly amongst part-time NAs. Enrolled nurse employment peaked in 1985 and has been steadily declining since, with a slight shift from full-time to part-time employment. There was a steady increase in registered nurses, mainly of full-timers, although data from 1989 overstates their increase (HPSSS, 1990:56-57;1992:54-55). This data gives some further clues to the complexity of effects on grademix taking place in the 1980s but, at this level, again provides few explanations. Thus, before turning to managerial views on grademix in the 1980s, the service, training, and sectoral effects on grademix need to be evaluated.

Service Changes

The three main HCHS services in terms of magnitude of nursing employment are: general nursing, mental illness and handicap, and care of the elderly, with the latter two being the so-called 'cinderella' services. These services employ very different grade-mixes. The broad distributions in 1988 can be seen in Table 7.4.

TABLE 7.4 GRADEMIX DIFFERENCES BY SERVICE

	% Qualified	Unqualified	Learners	Total No.
General Nursing	57	14	29	161,110
Mental Illness and Handicap	51	38	11	90,570
Care of the Elderly	55	45	-	41,150

SOURCE: Calculated from NHS Workforce in England, 1990: p C18

Data are extremely poor and unreliable at lower levels of aggregation. However, using Management Side Evidence for the 1991 Review for the years 1985-1989 (pp56-61) and prior to the later data confusions, it can be seen that there was an overall decline in the total numbers of nursing staff involved in general nursing and in care of the elderly. In general nursing, there was a slight increase in qualified staff, with the losses being accounted for entirely by NAs and learners. In care of the elderly, there were losses of both qualified and unqualified staff but the losses were disproportionately centred on NAs (12% against 5%). The largest losses of NAs overall were in this service. Within mental illness and handicap, by contrast, with a very modest overall employment growth, employment of qualified nurses remained level while NA employment slightly increased. Grade dilution therefore continued and offset a decline in learners in this part of the service.

There appeared to be two particular effects on the demand side. Firstly, and consistent with fieldwork findings, the 1980's have witnessed absolute service losses in care of the elderly in terms of both nursing staff and beds (for the latter, see HPSSS 1990). This

has also occurred in parts of general nursing, particularly for long-stay beds as the distinctions between care of the elderly in specialist or general wards and hospitals have become increasingly blurred. The flip side of this decline in NHS provision has been an expansion in private sector provision with private nursing homes accounting for the largest share of the increase in private healthcare value. This process is also taking place in provision of mental illness and handicap facilities as large public institutions are closed down; this has yet to feed into nursing statistics, although it was strongly noted in fieldwork interviews.

The effect on grade-mix has been relatively 'mechanistic' to the extent that implicit customary decisions about appropriate grade-mix have continued or been reinforced. It was noted in Chapter 2 that grade dilution occurred, in part, as cindarella services expanded in previous decades. Likewise, grade 'enrichment' appears to occur as such services contract and disproportionate numbers of NAs and ENs are lost. Thus, the underlying process of grade dilution is not negated and this could clearly be seen in its continuation in mental nursing. Under conditions of relatively stagnant overall employment, this has been an important effect, both in explaining the stagnation and, in part, the changing grade-mix. This 'sectoral shift' is policy- and resource-driven and it was clear from local interviews that the 'rationalisation' of services had proceeded apace, particularly in the latter part of the 1980's and prior to the NHS reforms. This cannot be considered to be unlinked to national policy on private healthcare activity, as will be seen below.

To the extent that shifts can be observed within general nursing from long-stay to higher-tec nursing, and with a growth in the higher-tec specialities, it is clear that the influence of managerial or professional judgement must also have been important in producing specific grade-mix combinations. Such judgement must also have been influenced by changes in training, which are now reviewed.

Training

Training changes have had a strong effect on grade-mix in the 1980s. Training levels continued an historic trend of decline but this decline became critical in the 1980s. The number of learners of all types (students, pupils and post-registration) continued its historic decline, both proportionally and absolutely. With the exception of very small numbers of post-registration training specialties, the decline has been steady in post-registration training and in first and second level (pre-registration) nurse training, with a slight upturn in the latter from 1989 (see Management Side Evidence, especially 1992:55). Most dramatically, pupil (EN) training, whilst previously on a steady decline, has now virtually disappeared; there were only 347 new entrants in 1991, compared with 6,000 in 1986 and over 20,000 in 1982. This decline was under way prior to its official incorporation into training policy as part of the Project 2000 exercise (detailed below) which has now 'red circled' the EN role. Conversion to 1st-level registration has so far been slow (see Nursing Times, various issues) and may continue to be so if not fully funded by the employer (Staff Side Evidence for 1993, 1992:17) although it may have slightly 'boosted' RGN numbers. By 1990, given slow gestation and funding implications, Project 2000 students had barely fed through into the overall picture with only just over 1,000 students, although this figure rose to 4,000 in 1991.

It has been argued that the decline in EN training occurred mainly because of demand conditions with training schools no longer keen to offer this training (Clay,1987:105). However, for a grade which has been referred to as 'one of the health service's biggest confidence tricks [with] pupil nurse courses filled in the 1950s and 1960s by recruits from Mauritius, the Phillipines and elsewhere, who were misled into believing they were doing a registered nurse training that would put them on a secure career path' (ibid), it is also likely that strong factors were operating on the supply side, not uninfluenced by the grade's low pay and poor promotion prospects. Most importantly, the supply of foreign recruits had been in decline since the 1970's.

These effects naturally fed through into employment. As noted, EN employment peaked in 1985 and has been in steady decline since then.

Thus, despite the apparent continuation of earlier trends, the 1980's witnessed what might be considered to be a relative crisis in training and an impending crisis in employment as, with or without conversion, there would be a smaller pool of qualified nurses to draw from. Figures from Management Side Evidence for the 1992 Review (pp54) show that the gap between numbers of nurses completing pre-registration nurse training and the net losses of qualified staff dangerously narrowed during the latter part of the 1980s to the extent that few managers in interview were confident of keeping up their 'professional' workforce. The concomitant decline in post-registration of midwives, health visitors and district nurses is also of considerable concern given proposals for increased 'care in the community' in the 1990 NHS and Community Care Act.

Growth of the Private Sector

The growth of the private healthcare sector in the 1980s has, in part, fuelled and accommodated the service shifts in the public sector and bolstered the changes in grade-mix. It has not, however, resolved the wider pressures of demand for healthcare and nurses and it has introduced new problems for future changes in grade-mix in the NHS.

Private healthcare expenditure rose from 0.5% of GDP in 1979 to 0.8% in 1986 (see The Directory of Independent Hospitals & Health Services 1988/89), and has been continuing to rise since. In 1989, private and voluntary hospitals and nursing homes supplied 15.3% of all U.K. hospital-based treatment and care compared with 7.5% in 1984 and the value of such services amounted to £2.7 billion in 1989, split between acute services and non-acute nursing home care (from Laing & Buisson, 1991 in NAHAT, 1991:210). Even taking public and private provision in combination, there is little evidence that this change in public/private sector mix has improved the U.K. position in the international league or satisfied additional demand from demographic

and technological change. Public and private healthcare expenditure in the U.K. jointly add up to a significantly lower proportion of GDP than that found in many advanced capitalist countries (see EEC comparisons in RHSG, 1987:100-101, and OECD figures in Harrison et al, 1990:42) and overall expenditure for the public and private healthcare sectors remained fairly constant as a proportion of GDP from 1981 (see Harrison et al, 1990:34) against slow average annual growth in GDP itself during the 1980's. The main change appears to have been a substitution of private activity for public activity.

There has been a measure of success in 'rolling back the state' with respect to healthcare in line with Conservative policy. The Conservative Research Department stated in 1986 that 'the Government believes that a thriving private sector strengthens the NHS by relieving some of the pressure on it and by providing an alternative way of developing good practice and improved forms of treatment' (quoted in RHSG, 1987:108) and this position was maintained in the White Paper of 1989 'Working for Patients'. Taken literally, the basis for this view remains highly contentious. RHSG, for example, have argued that 'there is no evidence to suggest that the growth of the private sector since 1979 has strengthened the NHS...furthermore the question of its impact on health has not even been raised' (ibid:121). Nonetheless, private healthcare has clearly substituted for the public sector in some aspects of healthcare provision.

A closer examination of the two halves of private sector activity - hospitals and nursing homes reveals, however, that this has been at cost to the public sector and also rebounds upon nursing grade-mix and employment in the NHS. In the private hospital sector, over 55% of beds are now owned by for-profit operators, with this accounting for over 60% of all revenue (Fitzhugh Directory of Health Care Information Services 1988). The huge expansion in what should correctly be termed the 'independent' sector has occurred in the for-profit growth of hospitals, with charitable provision remaining roughly constant in terms of hospital numbers and beds and therefore declining as a proportion of total provision (see Table 7.5). American groups formed

the largest proportion of profitable activity in 1986 (RHSG,1987:110) although NAHAT note the 'most remarkable trend' of the late 1980's for European groups to be replacing US groups (1991:212).

TABLE 7.5 GROWTH OF HOSPITALS IN THE INDEPENDENT SECTOR

Year	Type of Provision	Hospital Numbers	Beds	% of Total Provision
1979	Charitable	88	4775	71.4
	For Profit	62	1916	28.6
1988	Charitable	87	4679	45.1
	For Profit	116	5692	54.9

(Source: Laing & Buisson 1987 for 1979 figures, and Independent Hospitals Association for 1988 figures in Buchan, Nursing Standard, 28 March 1990).

The extent to which such private sector growth has 'strengthened' the NHS through taking on work which would have been handled by the NHS, or by setting an example of best practice, is much disputed, not least because 'efficiency' gains would have to be offset against the need for profit. There is little doubt that 'it is still only a small minority of the population who have access to these services' (Harrison et al,1990:53) and that the growth of profit-oriented healthcare therefore distorts provision. The services are concentrated in the South East, with 'private medical insurance [the main form of funding] still concentrated in the more affluent parts of the country and the social spectrum' (RHSG,1987:115) and largely promoted through company schemes rather than individual subscribers (at the end of 1989, there were an estimated 3.4 million policy holders in the UK - NAHAT,1990:111). However, such subscribers are 'the people who are less likely to experience ill health' (RHSG,1987:121).

The expansion of the second main activity of the private health sector - that of nursing homes and care of the elderly - also has wider implications. Private nursing homes have accounted for the largest share of the increase in private healthcare value. After ophthalmic services and fertility regulation, care of the elderly is now the most highly privatised sector of mainstream healthcare in Britain, with

care provided in institutional settings absorbing the bulk of resources. According to NAHAT, the run down of local authority provision was followed by a rapid expansion of private residential homes and, a little later, by a similar expansion of nursing homes. This took place against a background of 'static or declining provision in NHS long-stay geriatric and psychogeriatric wards':

Much of this expansion in private sector capacity has been funded by supplementary benefits (now income support)...social security funding of residents in private and voluntary residential and nursing homes in Great Britain (all client types) rose from £10m in 1979 to an annualised figure of £1,270m in May 1990. With the implementation of the Government's community care reforms now being phased, income support will remain the largest and fastest growing source of public subsidy for people entering nursing and residential homes, until the budget is transferred to local authorities in 1993 (1991:210,214-215).

In 1990, there were an estimated 319,000 places in private and voluntary homes for the elderly compared with 211,000 in all public sector establishments. 36% of the cost in long-term care of the elderly was publicly financed and supplied, 24% publicly financed and privately supplied (mainly through DSS vouchers with a small balance through contracts), 34% privately financed and supplied and 6% privately financed and publicly supplied (local authority charges). NAHAT have suggested that the decline in the volume of NHS long-stay provision:

is likely to continue or to accelerate as the NHS is forced to focus its limited budget on acute and primary care. Local authority provision has also started to decline in the last few years as financial pressures have increased (ibid:214).

The independent sector has also been playing a 'major role in creating new facilities for mentally ill and mentally handicapped people as large NHS institutions are run down'. In 1990, such facilities accounted for around 23-24% of the institutional bed stock - with the increase also overtaking public provision (ibid), though, as noted, these changes have yet to appear in nursing employment data.

The general lack of national standards and accountability for the independent sector mean that little statistical evidence can be

provided for the government's arguments about 'best practice'. A growing amount of evidence now exists concerning standards of care in the private homes sector, however, which would suggest that 'relief' measured on a cash or bed basis would not be appropriate. One of the few systematic reports on private residential homes for the elderly, 'The Realities of Home Life', commissioned by the West Midlands County Council Economic Development Unit and co-published by NUPE, found that:

the majority of homes in no way conformed, or were attempting to conform, to the standards of care, staffing levels and quality of life as laid down by the Government's own Code of Practice (1986:22; see also Charter for Community Care, COHSE, NALGO, NUPE, 1991:10).

Sharp practice on fees in nursing homes has been acknowledged by Tony Newton, Conservative Minister to the House of Commons Social Services Select Committee (11.6.91): 'the exploitation is widely acknowledged...but there is nothing I can do about it' (11.6.91, HMSO). Fraudulent practice and abuse of patients has also been reported (see, for example, Observer, 21.7.1991). In part, as a divisional trade union official explained, the problem lies in the fact that council and health authorities lack the physical resources to check on standards of care and the financial resources to take over responsibilities if a home has to be closed 'so social services fight shy of deregistration'. Interviews with the appropriate manager at a district health authority in the West Midlands region in an urban area suggested that standards vary between HAs: 'we're strict on 24-hour RGN or RMN cover here but some other HAs allow second level nurses'. The particular HA concerned had never closed a home despite the recent growth in numbers. Thus, although growth in private homes has nominally 'relieved the NHS' it has been largely funded from public expenditure elsewhere (DSS) which now has also to allow for a profit element, and the 'quality' of care remains very contentious.

Both types of private sector expansion have affected the type and variety of provision in the NHS and to this extent have affected grade-mix and employment of nurses in the NHS. The growth of

employment of nurses in the private sector is shown in Table 7.6. This shows that between 1982 and 1988, the number of qualified nurses in the independent sector (hospitals, homes and clinics) doubled, while there was a three-fold increase in the number of unqualified nurses. The trend has been continuing upwards since then, so it is likely that there are now more than 60,000 nurses working in the independent sector. This probably understates the increases due to definitional problems over unqualified staff working in nursing or non-nursing residential homes, for example as care assistants.

TABLE 7.6 NURSING STAFF IN THE INDEPENDENT SECTOR
(whole-time equivalents, England)

	Trained	Untrained	Total
1982	12,208	10,416	22,623
1988	25,836	30,611	56,447

Source: J. Buchan, 'Growing Independents', Nursing Standard, March 28, 1990) and the National Audit Office, The NHS and Independent Hospitals, (1989, HMSO).

A study on the movement of nurses between sectors indicated that the NHS experienced a gross loss to the independent sector (hospitals and homes) of about 1,800 qualified nurses in 1985 with the net loss representing about 0.4% of their total qualified nursing manpower (Thomas, Nicholl and Williams, 1988). Though this figure may appear small, it may be set against the total increase in total nursing staff for the NHS of only 0.6% mentioned above for the whole period 1982-1990 as opposed to the single year covered in the study. The 'leakage' is concentrated, in the case of private hospitals, in specific regions and specific groups within the NHS workforce, especially nurses under 30 years of age with specialist skills such as theatre nursing, renal nursing, intensive care and oncology.

The study suggested that the future growth of private hospitals might quite substantially deplete the pool of qualified theatre nurses available to the NHS. Regional concentration has traditionally been in

the South East, but the evidence in the previous chapter suggested that developments in the West Midlands are now giving rise to shortages of nursing staff in certain specialities through competition with the private sector. Younger, specialist nurses are very mobile, so leakage spreads to all regions. NAHAT have observed that 'the increasing scale of private activity alongside the expected national nurse shortage will ensure that transfer of scarce skills from the NHS remains a live issue' (1991:212).

Evidence on unqualified staff, where the greatest leakage has occurred, is even less satisfactory than that on qualified staff. Whilst it is apparent that leakage has occurred it is not possible to identify the balance between experienced ex-employees of the NHS (a formal loss of expertise for the NHS) and people employed from the same pool that the NHS would obtain staff. One nurse manager suggested in interview that, in either respect, this had become an increasing problem in the 1980s and would have implications for the proposals on NHS grade-mix in the 1990's. In the DHA concerned, there had been a massive expansion in local private homes at the same time that the HA was attempting to change grade-mix in favour of cheaper, unqualified staff.

The growth in private healthcare activity has thus had mixed effects on nursing grade-mix and employment in the 1980's. In one respect, it has relieved some of the pressure of demand in the NHS, although the extent of such relief and standards of care remain very contentious and much of the shift has still been underwritten by the government from public funds. In another respect, it has increasingly been competing for scarce staff and benefiting from NHS training. With the major growth in healthcare demand coming from the growth in the elderly population, this analysis cautions against simplistic propositions on future grade-mix in the public sector and demonstrates the importance of locating grade-mix against the wider provision of healthcare.

Managerial and Professional Judgement

The preceding sections have shown the increasingly narrow margins within which management have been able to exercise judgement on staffing but this may be seen to be particularly important in general acute nursing and the higher-tec specialities. Such judgement may be influenced by national initiatives, by local resource constraints and by 'professional' or 'judgemental' values. Nurse managers have to make day-to-day decisions on appropriate grade-mix. Whilst this process remains relatively invisible in the large and poorly documented area of general nursing, fieldwork interviews with managers and nurses suggested this was an important issue, despite the Griffiths managerial reforms and a generally-acknowledged loss of power and jobs for senior nurse managers (see Strong and Robinson,1990). In part this is explained by the tenacity of those managers who have remained in place and managed to define a role for themselves, but in part it is also explained by the fact that 'professional' values are inculcated at much lower levels in nursing. Interview results were relatively invariant to the level of nurse manager (district, unit, ward) and demonstrated a 'collective' view on professionalism.

It is difficult to see how nurses could be entirely excluded from employment decisions as nurse managers who have been placed in 'quality assurance' capacities or asked to assume managerial responsibility can hardly separate who is hired and on what grade from questions of quality. Whilst there were some nurse managers in interview who felt they had been excluded from this process and despaired of it, others had managed to make plain to other managers that they had a vital role to play. There can be little doubt that wider politics, macho styles of management and views on professionalism and quality of health service provided on the part of other managers, particularly general managers, has had a vital influence on the differential outcomes for nurse managers.

The pay review process and the development of Project 2000 ensured some measure of success for the 'professionalising' element in nursing, in terms of both pay and status, and this could have been expected in the context in which the PRB was formed. The employment statistics reviewed earlier suggest that full-time qualified nurses were 'preferred' in the 1980's, particularly in higher-tec areas, even under resource constraints and within the overall stagnation of employment. Managers, whilst conducting skillmix reviews inspired by national initiatives, appeared to resist grade dilution and the potential cost saving to be made in this way.

The fieldwork interviews suggested that the great majority of nurse managers had a strong professional identification and clearly felt that they had exercised 'clinical judgement' in grade-mix decisions. In the changed circumstances of the 1980s, the grade-mix of 60:40 represented a new and desirable 'benchmark'. A fairly typical manager reported his view of grademix in the 1980's. He identified some of the pressures of the 1980's as he saw them in terms of staffing the wards of his hospital. New technology and increased throughput had increased the demand for qualified nurses, with more complicated equipment to monitor. Shorter stays produced a higher dependency of patients. Qualified nurses' time had been increasingly occupied by administrative duties in line with national and regional initiatives and the NHS reforms. Learners, who are part-trained, were in dwindling supply.

Faced with the choice between filling a vacancy previously occupied by a qualified nurse with an inexperienced NA or a qualified nurse, he would opt for a qualified nurse albeit, if possible given labour supply constraints, one on a lower grade (ENs were target groups for a number of managers). His hospital had seen a run-down of its elderly and long-stay facilities in favour of limited, hi-tec service development. Where service developments did occur, this manager and many others had staffed according to their perceived needs for grade-mix. Thus, although skill-mix reviews of various types had been conducted, this manager clearly felt that his professional judgement

remained the final arbiter in balancing quality and cost considerations. The manager also noted that professional judgement could also be used on occasion to overrule the findings of skill-mix reviews when these suggested more staff were needed: 'skill-mix reviews are a double-edged sword'.

This general view was echoed by many managers. Whilst work had undoubtedly intensified for all the nurses under their remit, and whilst 'extra pairs of hands' had not been available because of resource constraints, most felt they had aimed to survive the 1980's with a nursing workforce just about intact and able to attend ill people. There was a high degree of agreement over the 60:40 benchmark and one manager defended it, suggesting that:

'the grade-mix is a conscious decision, made for clinical reasons...fewer qualified nurses would represent a drop in quality'.

However, a number of the districts, and the region as a whole, were moving rapidly towards a 50:50 grademix and all the managers saw grade dilution occurring in the future. The main impetus was perceived to be the change in training taking place in the late 1980s under circumstances of already tight resource constraints.

RECENT CHANGES AND PROSPECTS FOR THE 1990s

If managers viewed the end of the 1980s as an emerging crisis point in nursing provision, changes in training were to exacerbate this position, but also to expose the underlying contradictions and disagreements over 'professionalism' and 'professional judgement' and thus to challenge notions concerning the ideal shape of the nursing workforce and its grade-mix.

Changes in Training

It was noted in the first part of this chapter that the historic process of grade dilution appeared to break down in the 1980's, despite a continuation of the basic principle of grade dilution in the

cindarella services. This occurred through a complex interplay of changes in employment, service, training and sectoral provision, and partly as a result of managerial judgement. An increase in the proportion of registered nurses was thus achieved, particularly in higher-tec areas.

The importance of managerial judgement becomes less surprising against the background of the early 1980's. It was seen in Chapter 3 that the balance of power was shifting in the 1970's and early 1980's towards the TUC-trade unions, in part as a result of grade dilution. The 'greater' problem for the government in the early 1980's was how to resolve the industrial relations and electoral issues and avoid a pay spiral occurring. The first step was the establishment of the Pay Review Body and there seems little doubt that the intention was to restore the 'balance' in favour of the more moderate professional organisations and that this, in membership terms, succeeded. The pay review process, however, had the slightly unexpected effect of highlighting recruitment and retention problems. The shortages noted throughout the pay review process were almost universally acknowledged to be a growing problem. On one account:

The one brute demographic fact on which everyone is agreed is that the traditional pool of recruitment for nursing - girls with 5 'O' levels or 2 'A' levels - will contract until the mid 1990s and will not recover to the levels of the 1970s and 1980s in the present century. On current trends, nursing would need to recruit almost half of this population by 1995 in competition with higher education, other health and welfare occupations, teaching and the wider employment opportunities for women resulting from the weakening of sex discrimination. Just to state this is to recognise its implausibility. (Dingwall et al, 1988:224)

It would, of course, have been possible to address existing and potential shortages through higher pay settlements for trainee and registered nurses. However, pressure had also been building from the professionalisers for educational reform. Numerous 'stalling' operations on the part of successive governments over potentially expensive training changes had included the establishment of the United Kingdom Central Council for Nursing, Midwifery and Health

Visitors (UKCC) and English National Board (ENB) (see Dingwall et al,1988:Ch.10) which had an important influence on the project along with the RCN. With the shift in the balance of power, these pressures became more urgent.

It was against this background that Project 2000 was born. Project 2000 was in part a response to prior pressures from the profession, in part a concession and in part an attempt to address future shortages of qualified nurses in the context of *de facto* reduction in EN and SRN numbers, high wastage and demographic trends without increasing pay. Project 2000 was also very much a continuation of the much older debate on professionalism and education which dates back to the 19th century and was explored in Chapter Two.

Ostensibly, Project 2000 represented a remarkable achievement by the professionalisers. The Nurses and Midwives Act of 1979 had established the UKCC and given it the responsibility for maintaining the register of nurses, and co-ordinating nurse education throughout the UK. In 1985, the Council established a project team to review and recommend a new approach to nurse preparation which produced its first report, Project 2000: A New Preparation for Practice (UKCC,1986). The final report, submitted to the government in January 1987, became known as Project 2000. Its proposals were broadly in line with earlier reports from the RCN (1983-5 Judge Report) and the ENB (1985).

Project 2000 proposed that nurse education should be more closely associated with the rest of the higher education system in the UK. Thus, student status should be protected and student nurses not used as a significant part of the labour force. It was envisaged that students should receive training grants which would be primarily NHS controlled and derived from a separately identified education budget (1986;70), which also had the effect of removing another large staff group from the remit of pay review. A common foundation programme for all students, after which they could specialise, was also proposed. The period of education and training would remain three years of which 18 months would be core programmes and a further 18 months branch

programmes in which students would concentrate on nursing of adults, children, the mentally ill or the mentally handicapped. The new single-level 'registered practitioner' was to replace the present first- and second-level nurses (SRNS and ENs). The Report was initially greeted by professionalisers as 'the biggest change in nursing since the days of Florence Nightingale' (Clay, quoted in Health Service Journal, 26 May 1988).

Many of the TUC trade unionists saw it instead as a confirmation of union fears that the government wanted to bring in cheaper nursing (Bob Jones, NUPE in *ibid*) and this quickly also became a concern of the professionalisers. At first glance, there seemed to be little in Project 2000 to reassure policy makers on either demographic or cost grounds. Far from widening the entry gate, Project 2000 looked set to raise the standards and slam the gate shut to achieve a degree of professional closure. The immediate cost and staffing implications included the reduction of student labour input on wards, extra investment in educational facilities, and the loss of ENs. Potential cost benefits were supposed to be grants rather than a competitive wage, reduction of wastage during training and of ward staff teaching time. The cost-benefit estimates on the RCN and UKCC proposals that suggested moderate or no additional expenditure (see Dingwall:225-226 for a detailed discussion of some of the problems) failed to be very convincing; particularly given the general assumption that auxiliary labour would be used to fill the gaps created by supernumerary status of students. Thus, 'a warm government welcome for such an expensive venture seemed unlikely' (Gould, 1988). However, the government appeared prepared to proceed with Project 2000. Reactions quickly followed, firstly on the terms of Project 2000 itself; for giving nurses in training true student status, the profession would have to be generous and flexible in formulating entry requirements so more school leavers and mature students could qualify for admission to the craft, with credit being given for experience, and 'aides' would have to be able to earn a place in training schools; time scales and funding were left vague (*ibid*, also letters from Moore, Kenneth Clarke and Audrey Emerton of UKCC).

Secondly, and almost concurrently with Project 2000 and the idea of aides or support workers, the government-led proposals for National Council for Vocational Qualifications (NCVQ) certificates for Health Care Assistants (HCAs) arose and undoubtedly added to the speculation over grade dilution. NVQs are a national scheme, spanning the NHS, local government, private and voluntary sectors across the labour market. NVQs were intended to be acquired mainly on-the-job with maximum horizontal and vertical flexibility for both worker and employer through a system of module and performance-assessed credits. A Care Sector Consortium was established to examine all work below the 'professional' level (i.e. below RGN level) with different 'levels' being envisaged (NHS Training Authority, October 1988).

The scheme had already been linked with the idea of Project 2000 and Support Workers. A prior NHSTA report, which Dingwall et al note 'ceased to be available shortly after its publication in March 1987' (1988:226) had already put forward a view of support workers which differed 'radically' from that of the nursing professionalisers involved in Project 2000. Here support workers were seen as having clear and direct responsibility for patient care, with specific training which would form part of a modular pattern of education extending right across the service. Entry might come from unqualified school leavers on YTS or mature men and women with limited past educational opportunities. Most importantly, an appropriate accumulation of credits would qualify support workers for entry to nurse training. Along with these reports, the DHSS, MSC, NHSTA and UKCC commissioned a 'Feasibility Study into YTS in Health and Social Care Programmes', the final report on which was presented in November 1987. The report concluded that YTS would be 'less costly from the NHS perspective than alternative programmes for training support workers' and that 'YTS in care within the NHS is feasible, and should be encouraged' (in *ibid*:3-4).

It was the question of 'levels' and entry points which raised the greatest speculation amongst professionalisers. If the 3rd level was to be an entry point to RGN training (Nursing Times, 1st June,

1988:13), this would threaten the 'educational' qualification basis of entry to Project 2000 training. Moreover, a 4th level was envisaged as a 'professional' level with further levels being planned and this led to further speculation about how this scheme would sit with Project 2000 and traditional nurse training.

The vast majority of interviewees for this fieldwork, saw grade dilution as the overwhelming reason for the government's acquiescence to Project 2000, with the project providing an excuse for significantly fewer expensively trained and reasonably paid nurse practitioners working alongside many more of the cheaper aides carrying out a lot of the duties currently conducted by qualified staff. According to Gould, these views appeared confirmed by a press briefing, shortly after the government's welcome for Project 2000, in which a Department of Health and Social Security spokesman:

revealed that this is exactly what the government hoped to see happen, particularly in the case of chronic invalids, the handicapped, the elderly, and others whose condition is not liable to sudden change...similar ideas were contained in a report on the future of community care prepared by Sir Roy Griffiths (1988).

Whilst professionalisers were worrying about the widening of the entry gate or a completely alternative training structure, other worries were surfacing about whether training would be provided in time or at all. Initial concern was expressed by unions and NAHA that 'since full details of the national training and accreditation package for Support Workers will not be available until the summer of 1989, Authorities introducing Project 2000 in 1989 will initially need to develop their own training arrangements based on such national material as is available' (letter from Len Peach, Chief Executive of the NHS Management Board to General Managers, October 1988). COHSE expressed particular concern that there was 'no assurance that local managers will be obliged to train Support Workers according to the NVQ framework. However, we do know that the 'opt out' hospitals will not be forced to do so' (Briefing Memo, 17 April 1989).

Concern about the lack of adequate funding for both Project 2000 and NVQ training has continued to the present. A senior manager of a large training college for a 'flagship' hospital in the West Midlands admitted in interview that they had been forced to put carefully-laid preparations for Project 2000 on hold because of 'the major cost implications and underfunding'. The manager noted that solutions to this delay would involve either 'more funding or cheaper nursing'. The latter solution, however, conflicted with a need to improve retention in clinical areas and to recruit ever more HCAs or nursing auxiliaries to fill the gaps left by 'supernumerary' status of students which might imply the need for higher wages. As Staff Side have noted, replacement staff 'will have to be employed from outside the currently available pool of recruits' (Evidence to PRB,1992:17).

The extent of this need is clear; employed student nurses form around 30% of the nursing workforce (1988 figure) and account for well over half the staff available on some wards (Audit Commission, 1991:32). It could also be seen in Table 7.4 that students have been disproportionately employed in general nursing where managers achieved some degree of success in exerting their 'professional judgement' and enriching grade-mix in the 1980s. Staff Side, taking into account the conclusion of the Audit Commission that an overall assumption of a 50:50 grade-mix of additional registered nurses and NAs is appropriate, estimated that full-scale implementation of Project 2000 would 'result in a shortfall of around 33,600 (wte) nursing staff at the 1990 staffing levels (taking into account the 20% Service contribution estimated for Project 2000 students)' (Evidence to PRB,1992:17).

In these respects, the irony of the 'professional' advance signalled by Project 2000 is that it has caused immediate problems for nurse managers in the very areas in which they have managed to exert a degree of professional judgement and against an already perceived crisis in resourcing. Paradoxically, the slow advance of Project 2000 has staved off an exacerbation of the immediate crisis whilst failing to correct for the decline in training. Equally, the slow

advance of NVQs and Health Care Assistants has staved off any exacerbation of training costs whilst also failing to provide a possible solution along the lines envisaged for these groups.

Managers in interview were gloomy about the trends and grade-mix implications. From their view, Project 2000 was costly and any serious attempt to train for NVQs would also be costly in terms of supervision and training time. To the extent that both these projects advanced, they would leave a gap of both ENs and students to fill and the training changes in the 1980s had, in any case, already been inducing this effect. ENs were viewed as, in one manager's words, 'the backbone of the service', with relatively low turnover. Another manager noted that 'if you get rid of the EN, you will have to reinvent them' and this point was made by many managers and staff side representatives. Most managers saw a target group of mature women for the role of 'plugging the gap' and only one felt that YTS would offer any possibilities, with the others feeling that a lack of experience, in particular life and caring experience, would largely make YTS trainees more troublesome than useful as they would need a large amount of supervision. An interview with a TEC manager overseeing YT/HCA progress in a London Trust Hospital also suggested very limited scope: youth trainees were poorly motivated because of low pay and the nature of the work, there was a high turnover and only a very small proportion were taken on in permanent employment or went on to nurse training.

Managers viewed part-timers as target staff for both qualified and unqualified posts, and the proportions had been rising in nearly all the districts, along with competition for this group of workers. Managers were divided over whether the use of agency staff was cost-effective or not; few, however, wanted to increase agency staff use as quality of care was generally considered to be reduced and tensions created with permanent staff. Bank staff were preferred but one manager noted that these were frequently nurses who already worked at the hospital but could not manage on their salaries. The scope for expansion was therefore limited. All the fieldwork interviews revealed

fears over grade-mix changes. One nurse manager put it thus: 'where will all the qualified nurses be when I am old and in need of nursing care?'.

The Drive to 'Reprofile' the Nursing Workforce

Alongside the above changes in training and their grade-mix implications, have gone a number of studies, initiatives and exhortations at national and regional level. These have mainly addressed the issue of 'skill-mix' from the premise that an 'efficient' mix has not been achieved in terms of cost.

As noted earlier, rather different, though interlinked, concepts are in practice involved in most of these exercises. First, skill-mix might be defined as 'an assessment of the relevant skills and experience required of staff in a particular work environment' (Buchan & Ball, 1991:28). The inclusion of 'experience' may or may not be appropriate and it will be seen that experience is frequently considered apart from 'skills'. Second, grade-mix refers only to the assessment of different mixes of staff in a work environment and grading may or may not reflect required skill and experience. Third, task-mix, or skill substitution, refers to those parts of a job or a whole job that could be reallocated to other workers. Buchan and Ball note that few studies have addressed the issue of quality of standard of care/outcomes and some publications purporting to address skill-mix actually address grade-mix (ibid). A general lack of clarity in the literature, which was fully reflected in interviews, relates to the vital interlink between these concepts and the potential for subjectivity. For example, a logical ordering of the concepts from the point of view of management might be: to identify tasks to be performed, designate appropriate or necessary skill, and assess relevant grades and pay.

It may be envisaged that in a purely operational sense as soon as a combination of tasks arises, the assessment of skills becomes more complex. Moreover, the 'necessary' skill may be much disputed as will

be the valuation of that skill. As was seen in Chapter Two, the linkage between tasks, skills, and grading may not be clear, and may be influenced by other factors. Moreover, experience frequently does not enter directly into this analysis at all as it does not relate in any easy way with skills or the recognition of skills. Related to this last point, the problems are multiplied several times when the operation is regarded less as an abstract exercise and the background, experience, personality and motivation of particular individuals need to be matched to a combination of tasks, skills and grade.

Nonetheless, from the mid-1980s in particular, there has been a range of studies produced purporting to address the issue of 'skill-mix' for nurses. A National Audit Office report in 1985 found large variations in nurse staffing levels (NAO, 1985). This was followed by 'Mix and Match', a report from the then Department of Health and Social Security (DHSS, 1986) which found wide variations in skill-mix and staffing levels which, it was claimed, appeared unrelated to dependency levels and standards of care. Studies by Robinson et al and Ball et al (both 1989) suggested that some degree of 'non-nursing' duty reallocation to support staff was possible.

More recently, the issue has been driven along by the DoH. Staff Side Evidence for 1993 has a special section on 'Reprofiling' in which the cost-driven nature of these studies is noted, along with the potential for 'de-skilling' of the workforce. Staff Side notes that the NHS Management Executive Personnel Unit has been providing human resource workshops for NHS managers discussing changes to labour utilisation. The DoH's 'Value for Money Unit' has also been 'touring the country recommending reductions in the level of qualified staff' (1992:14). This drive has been supported by specially commissioned academic studies. For example, Dyson's April 1991 paper on 'reprofiling', commissioned by the Policy Development Unit of the DoH and published as part of the NHSME Trust Network series in September 1991 advocates changing skill-mix in favour of a larger 'peripheral' part of the nursing workforce, although some interesting additions have been introduced in the form of individualisation of pay and conditions and

casualisation of work through his proposals for personal contracts and self-employment. It is argued in the paper that standards of care can be improved at the same time that personnel costs are reduced. Countering the above studies have been a number of studies suggesting that registered nurses actually provide a cost-effective method of delivering patient care, not least because they can perform the widest range of tasks and spot potential problems earlier (see for example review in Buchan and Ball, 1991, Centre for Health Economics, University of York, October 1992, commissioned by DoH).

Staff Side have attacked the drive for 'reprofiling' on two main grounds. Firstly, the drive is seen as 'deskilling' in its implications for the contraction of registered staff. Secondly, and crucially, the impetus towards employing 'non-nursing generic care assistant' posts is being resisted as being in no way comparable to existing NA posts and the skills acquired through experience (1992:14-15). It is argued here that the drive to 'reprofile' has been enabled by the fact that it exposes the Achilles Heel of nursing, namely the historical conflict over the acquisition, recognition and valuation of skills and their relationship to tasks actually performed. This argument is pursued by exploring 'ideal models' of the nursing workforce.

Ideal Models and the Skills Debate

It became increasingly clear throughout the research and interviews that a number of normative 'ideal type' models of the composition of the nursing workforce are visualised by the government, managers, nurses and their representative organisations. These have tended to be implicit and largely unexplored in any consistent way for their logical coherence or pragmatic feasibility. The main models are summarised in Table 7.7. This incorporates the main training changes of the 1980's; thus, ENs are removed as 'red circled' and supernumerary students under Project 2000 also come out and the focus is placed on the registered/unregistered mix which is the logical end result of current changes. These models represent the main 'extremes'

that emerged through interviews though there were many variants on these models.

The Professional model assumes that some need for a second tier of workers remains although it may readily be envisaged that a more extreme version of 'successful' professionalisation could lead to an 'all qualified workforce'. It is axiomatic in this model that skills can be fairly clearly aligned with qualifications and grades and that valuation bears some clear relation with skills.

The 'Traditional' model encapsulates the historical development of nursing and is associated with government or management cost minimisation strategy. Its two main distinguishing features are that grade dilution occurs as a general tendency and 'less-qualified' or 'unqualified' staff balance out or even surpass registered nurses. In these respects it is the converse of the Professional Model. The Model does not address the barrier to the profession - this remains intact and NAs/aides/support workers, and ENs for as long as they remain, are still clearly subordinate. The system is thus hierarchically based and it is axiomatic that it does not explicitly address skill or valuation issues. The demise of ENs does not invalidate the general theoretical thrust of the model, although it has profound pragmatic implications.

Counterposed to both the above models, is the Radical Model. Its main feature is that it has a much more complex hierarchy and blurs traditional grade boundaries. It consists of a number of 'levels' with greater flexibility and mobility from level to level and far less likelihood of a professional barrier. On some views, there is possibly also a less hierarchical structure. The model seeks to deal much more explicitly with tasks, skills and valuation to explain the basis for its challenge to the other models. For this reason, it has been called the 'radical' model. From this point, however, fieldwork demonstrated some very different perspectives on the model. This was partly because of its relevance to radical right and radical left supporters.

TABLE 7.7 IDEAL MODELS OF THE NURSING WORKFORCE

MAIN FEATURES	MODEL TYPE		
	PROFESSIONAL	TRADITIONAL	RADICAL
Academic entry/training	Yes	Yes	No
On-job learning/experience stressed	No	No	Yes
Employment ratio in favour of qualified staff	Yes	No	Depends on Definitions
Curative role stressed	Yes	Yes	No
Prior caring experience valued	No	No	Yes
Task-based rather than Practitioner-based ethos	No	Implicit	Explicit
Mobile promotion structures	No	No	Yes
Flexible task borderline with doctors	Only if incorporated	Unacknowledged	Possibly
Flexible task borderline with ancillary staff	No	Unacknowledged	Yes
Higher ratio qualified viewed as cost effective	Yes	No	Unclear

The counterposition of a professional model with a government (or managers) keen to cost minimise and resolve shortages through grade dilution underlies much writing on nurse employment. For example, Dingwall et al. argue:

The professionalizers appear to favour moves to strengthen the competitive position of nursing by increasing the attractiveness of its training, working conditions and salaries. The managers seem to prefer the idea of dilution, looking for nursing tasks that could be performed by less expensive and more readily available labour. (1988)

However, the Radical Model, has become increasingly important in the 1980's and early 1990's (Dingwall et al are in fact amongst the few recent commentators to explicitly allow for this alternative type of grade-mix, albeit briefly, see paragraph, 1988; 227). It emerged as an important, though minority, strand in interviews with managers and trade unionists and accords with much of government rhetoric on 'flexibility' of both labour utilisation and pay.

If the ethos of NVQs ostensibly raised the possibility that government strategy now favoured a Radical Model, with or without accompanying pay flexibility, few actually interpreted this to be the case, as will be seen. However, the concept of NVQs hit upon the Achilles heel of the nursing professionalisers and caused great excitement amongst Radicals and it is therefore important to understand what 'enables' alternative models to the professional model. If the professionalisers were right, grade dilution would be a de facto skill dilution, the introduction of HCAs would be neither here nor there, and there would be a subsequent deterioration in either quantity or quality of nursing. In this respect the models would not be comparable. However, skill definition, acquisition, recognition and valuation are no more clearly defined in nursing than in any other occupation and the models frequently carry internal contradictions.

This becomes apparent in looking more closely at the models. For example, the debate over the training changes involved in Project 2000 and NVQs illustrated that deep-rooted differences between 'professional' associations and unions and TUC unions still exist on

the issues of grading and training, despite some apparent narrowing of conflicting interests through the pay review process. These differences not only reflect far deeper divergences over the issues of skill definition and valuation but also, more simply, the material basis for representative organisations' strategy. Different nursing representative organisations wish to hold or increase membership and represent members to the best of some defined interests. In this respect alone, though some agreement might be achieved over pushing up the ante and 'ratcheting' pay, unions and associations must necessarily maintain some basis for a common identity within their organisations with which to attract and represent members. However, these goals are not always clear or consistent and Project 2000 and NVQs perhaps challenge the basis of previous staff side organisations' strategy.

The Professional Model, and problems with it, are well illustrated by the debate over Project 2000. Despite a clear attachment to the concept of an 'all professional workforce' (see Clay,1987), it quickly becomes apparent that this is an idealist model which carries with it problems of access and therefore of shortages and inequalities. Moreover, the cost and pay implications could be expected to be prohibitive in the short term at least. In illustration, 'academic' entry standards, which appear to be a vital factor for most professionalisers, disqualify many people from gaining professional qualifications. This dilemma can be seen in the very obvious difficulty Trevor Clay has in putting the argument for Project 2000 and an 'all-qualified' nursing workforce. He points to the problems involved in 'the need to find ways to give young people who are educationally disadvantaged the opportunity to enter nursing', eventually suggesting that they should be 'sufficiently [self] motivated' and that 'much more needs to be done' to provide such young people with more opportunities to collect the necessary 'O' levels (1987:80-81). It is not so much that Clay neglects wider social and educational disadvantage as that his whole philosophy is founded upon a certain view of socio-economic structures and behaviour. This is a most fundamental divide, as was noted in Chapter Two. It thus also

becomes apparent that nursing auxiliaries are seen, failing 'an ideal world', as a vital component in the cost estimates for Project 2000 (ibid:104-105).

A further insight is given by the UKCC's own documents on Project 2000. The jargon used in the reports is of more than semantic interest. The UKCC proposed the replacement of the present 1st and 2nd level nurses with a single-level 'registered practitioner'. The later report called for the development of certified 'specialist practitioners' who would occupy a distinct clinical career grade as consultants to other nurses. The Project includes the recommendation that the 'practitioner should at all times retain responsibility for the care given to the patient or client and be accountable for that care...where the registered practitioner assigns work to a helper, the practitioner should remain always in a position to monitor that work, having due regard for the limits of competence of the helper' (1986:43). The following excerpts are instructive with respect to the perceived role of the helpers:

The helper should have a form of instruction which is limited and is suited to the setting in which s/he will work.

There must be no ambiguity on questions of the qualification, its transferability, and its possible status as a 'credit' for the entrant to professional preparation. The Project Group is of the view that a course of instruction for a helper prepares that person to work in one kind of setting. Further instruction is necessary if it is proposed that that person transfer to other settings or transfer between authorities.

Should the helper wish to prepare for professional practice, no barriers should be put in his or her way. Such a person, after all, will probably have a more realistic view of the role than will the new entrant from outside. The would-be entrant should be advised, however, that all the normal entry requirements will apply and that while work as a helper will serve to give an appropriate character reference, it cannot operate either as an entry gate or as a credit towards professional preparation.

It remains to suggest a title for the helper. We were anxious to avoid all the existing titles, in order to underline that the new practitioner had a new kind of helper. This eliminated [sic] 'nursing assistant', and 'nursing auxiliary'. 'Assistant nurse' not only has 'nurse' in the title which is misleading, but is also associated with the early days of the Roll and hence linked to a statutory grade. 'Care assistant' is a term in use in

social services. We have settled finally for 'Aide' [later to become Support Worker]. It is simple, it conveys the notion of being a helper and not a practitioner. There is even a chance that, being short, it may actually pass into everyday use and put an end to the indiscriminate use of the term 'nurse'.

The deep-rooted nature of the professional versus trade union divide is illustrated by these comments. The cost implications are also revealed in the obvious fears of the professionalisers. Perhaps in an effort to forestall the inevitable policy reaction, the UKCC suggested a 70/30 split between practitioners and aides, and noted that:

To conjure up a notion of a small cadre of registered practitioners supervising care, and a larger group of helpers delivering that care, would be quite contrary to the spirit of this chapter, as well as in contravention of the UKCC Code of Professional Conduct. It is emphatically rejected by the Project Group (ibid).

The 'Professional' view of skill is also well demonstrated in the following quotation in an argument for Project 2000 and the demise of the EN role:

Nursing requires a certain level of intelligence, skill and knowledge: it is a complex operation in which the so-called 'basic' and 'routine' part cannot be separated from the rest...the pace of life on wards and in the community is now such that the notion of qualified nurses adequately supervising, teaching and monitoring the work of the less qualified or unqualified is totally unrealistic. Such a separation of work and responsibility is not viable...The parallels drawn in the 1950s (Nursing Times 1955) between care of a sick person at home being carried out by an untrained relative and the utilisation of someone less qualified than a registered nurse to do 'basic' nursing in hospital are now totally outdated...patients in acute hospitals in the 1980s are admitted for much shorter periods in which they are usually very sick and dependent (Clay,1987:106).

The Professional Model reveals its flaws in that the skills required for nursing are not fixed or immutable or agreed upon and this represents the failure of the professionalisers to 'close the profession'. Whilst there might be a range of 'intellectual' capital that might be acknowledged to be necessary, the extent of this range and the way in which it is acquired (for example, through full-time academic study or on-the-job tuition or by simple experience and self-

tuition) would still be deeply disputed. Moreover, practical skills or communications skills may be underrated and influenced by wider social valuation. The skills thus become defined, acquired, recognised and valued by the complex interplay and negotiations between nurses and their employers, and between nursing organisations, professional or trade union, set in the wider context of relatively rigid socio-economic systems (see Wootton,1955). As was noted in Chapter Two, this also relates to the division of labour between paid and domestic activities and the 'undermining' of the valuation of nursing by the existence of (currently) over six million carers at home. It is in these respects that the Professional Model is *always vulnerable to an attack on its Achilles Heel.*

The Traditional Model has largely played upon these contradictions in the Professional Model. By leaving the 'ethics' of the nursing hierarchy well alone but by exploiting the variation between learning actually acquired and tasks actually performed and current valuation systems, grade dilution was 'enabled' and ostensibly consistent with a cost-minimisation strategy. However, as was seen in the review pay determination in the 1970s and early 1980s, such a strategy was not good for all time. 'Simple' grade dilution does not resolve the central conflict over valuation and material outcomes, and the grade dilution itself has union membership implications which then impact on pay and labour cost. The necessary shift to a more professional model in the 1980s and the embracing of Project 2000 could not be regarded as a steady state as this model always carries its own higher cost implications and therefore stands in the way of cost-minimisation.

Against this background, the emergence of a Radical Model, has been a natural development in terms of both the search for cost minimisation, and, paradoxically in the search for 'fairer' valuation. However, the roots of this model again lie in the deeper historical controversy over valuation. Proponents of the Radical Model would criticise Clay's view of professionalism for failing to recognise current realities and being elitist. For example, the role that a married woman, with caring responsibilities at home, plays in a part-time NA

or EN job with twenty years of work experience cannot be classified as 'unskilled'. Moreover, these staff groups are not utilised as such - there is thus a mismatch for many individuals between their grade, tasks actually performed and skill recognition. This mismatch became particularly evident during the clinical grading review, which could be seen as providing the basic structure for a Radical Model and pay individualisation. Thus, an apparent proponent of a Radical model, a nurse currently working in the Nursing Division of the Welsh Office, on clinical grading:

The creation of this new pay scale has to be viewed as a radical change in the culture of the traditional nursing organisation, not least because it has provided a measure of the worth managers give to the work allocated to different grades of nurse. In an organisation that has previously kept the roles and work of qualified and unqualified nurses so interchangeable that nursing auxiliaries, student nurses and registered nurses carry out the same care giving activities, any differentiation between the categories of nurse is a significant break with the past. (Keyser, in Robinson et al, 1992:115).

A number of interviewees made the same point about interchangeability of roles, particularly for the case of night duty, but the Radical Model emerged only as a minority view in interviews with managers and trade unionists. Although the 'valuation' debate underlay both versions, they differed in emphasis. Managers proposed a kind of 'meritocracy' whilst trade unionists were seeking more egalitarianism.

The managerial or meritocratic perspective proved to be a strange mixture of desire for managerial control and flexibility combined with some recognition that the current system is not 'fair'. Thus, clinical grading offered a way of escaping the professional hierarchy but also, by having a more task-based approach, recognition via grading and pay could be given to individuals for the work they actually perform, thus linking pay more explicitly to performance or productivity. Implicit in this view is the assumption that both experience and training add directly to the capacity to perform tasks in some measurable way and can thus be abstracted from the person performing them and geared directly towards the job. In this view skills are defined by the tasks to be performed and the 'meritocracy'

occurs as people acquire skills, by whatever means available. Such skills are firmly within management's remit for definition. The view further splits, however, over whether the emphasis for management of this system lies in having individuals carry out a multiplicity of tasks labelled as skilled and unskilled, the balance and drive for acquisition of skills being largely defined by managerial needs for flexible deployment, or whether the emphasis should be less 'radical' and lie in having tasks more accurately targeted to people who are defined as skilled or unskilled through such task allocation. The latter view commonly asserts that qualified nurses should be 'relieved' of mundane chores, although rarely addresses the issue of whether NAs and ENs, for example, should be relieved of more qualified work for which they receive no recognition.

In the case of the managers, there was an interesting coincidence of personal experience with the radical viewpoints they expressed. A not-unrepresentative background would be entry from the forces, sometimes at the lowest (orderly) level, and working their way up, acquiring formal nursing and educational qualifications along the way. Despite having 'made it', there was a clear feeling of resentment against the hierarchical and sometimes class-based attitudes they felt they had encountered along the way and the lack of meritocratic appraisal in the system. In a couple of cases, notably for educationalists involved in NVQs, there were clear vested interests in being identified with the changes. However, during the course of the interviews, it became clear that there was little agreement over the pay and cost implications of the model. In practice, managers were also very uncertain about the role of the HCA and NA in particular, whether NVQs would supplement or challenge the current hierarchy, what kind of people would take these jobs, what the training and funding implications were and how pay rates would emerge (see also Buchan,1992:17-27). At this point, most acknowledged that the model could spiral pay; it would therefore be necessary to limit upwards mobility and pay. One manager, involved in the setting up of NVQs in his unit, clearly outlined the emerging shape of his nursing workforce against normal resource constraints; the model, far from resembling

the Radical Model, in fact looked like an extreme version of the Traditional Model.

In the case of the trade unionists, there was a subtle difference of emphasis in their view of the Radical model towards a more 'egalitarian' perspective. The fair reward of individuals in an unfair society was of more concern than flexible task allocation. One officer, experienced in professional affairs, welcomed the debate that grading and training reforms had raised, feeling that it was long overdue. He noted that NAs in particular had been 'losers' throughout the history of nursing despite the fact that they were regularly 'exceeding' their job specifications and sometimes used interchangeably with qualified nurses, even to the extent of being left in charge of wards and giving out drugs.

He noted that such 'facts' were unpalatable to most managers and trade unionists alike as they raised uncomfortable questions about the status quo. Another trade unionist, a National Officer, confided that in practice, nurses were over-qualified for the jobs that actually existed. Caring for ill people involved a range of tasks and skills; if nurses simply attempted to 'educate' themselves out of the apparently more menial tasks then they also educated themselves out of the actual job to be performed. In this view, the problem was the valuation of skills and tasks rather than their distribution. This was emphasised by a senior nurse educational manager who noted that 'the problem is the low valuation of care work'. Many qualified RGNs felt that 'psychic' care (talking to, comforting patients) and the way in which physical care is conducted to be at least as important as the more 'technological' aspects of care or planning. A lack of value assignment to such a role, however, often left this to the lower, or unqualified, staff leaving a 'professional' role for RGNs which was some way distant from a rounded view of nursing as encompassing a wide variety of tasks and skills acquired both through the job and through life experience. As RGNs progressed, they thus got trapped into a 'medical' role of cure rather than care, as well as considerable pressure to relieve doctors of their tasks. A Research Officer

mentioned that inequity extended beyond nursing staff: 'why is it that ancillary work is regarded as non-direct care? It seems that male concepts of work are applied here - the whole value system needs to be queried'.

However, trade unionists were equally uncertain about the resource implications of a Radical Model, not least because their own success or otherwise in pushing for improved recognition, upward mobility and pay for NVQ staff would impinge directly upon these. There was a high degree of scepticism about the government's apparent support for a 'meritocracy'; all those interviewed felt that the Traditional cost-minimising model was bound to re-emerge in full force. There was a feeling, however, that the chance was too good to miss; the TUC trade unions were therefore highly active in ensuring that the terms and progress of NVQs were favourable and were keen to push through the beneficial parts of the scheme. This has been pursued with vigour in the latest Staff Side Evidence, where the term 'non-registered' was substituted for 'unqualified' and it was noted that 'in view of the fact that these nursing staff may possess NVQs in health or social care, the use of the term "unqualified" is no longer appropriate' (1993:3). As noted, semantics and status are important in nursing.

That these differing ideal models of the nursing workforce are held by various parties to the process of grading and grade-mix, and that their cost implications remain largely unknown, should caution a simplistic policy approach to 'reprofiling' the workforce. The workforce 'profile' in fact emerges as a historical progression through the interplay of government, managers, professional associations, trade unions, and nurses themselves, and the divergent views within these groups further complicate the process and produce uncertain outcomes.

A Return to Professional Judgement?

Despite the intense debate over different models, the majority of managers and nurse managers in the 1980's and early 1990's were more concerned with resource constraints. These managers clearly held a personal, normative identification with the Professional Model and it is this above all else which has occasioned the attack on their status and the attempt to put 'professional managers' in charge of workforce decisions rather than 'managers who are professionals'. It has been shown in this chapter that managers have undoubtedly had some influence in local hiring policy during the 1980's, albeit relatively unquantifiable against other changes influencing the enriched grademix. Managers' explanations for their own behaviour, however, was based far more upon pragmatic and cost considerations and it has been shown that there is some evidence for this view.

In their judgement, the 1980's produced particular problems which they had resolved to the best of their ability against severe resource constraints. To this extent, gloom rather than idealism characterised their view of the debate around ideal models. In the early 1990's, most felt that whatever views they held personally would be railroaded by the NHS reforms, even greater underfunding and the drive to 'reprofile' the nursing workforce. The training changes were also seen as imposing costs which would force through what might be termed a New Traditional Model. The difference for them was that this New Model took no account of the fact that the system was already stretched to the seams. Nurses throughout the hierarchy had assumed extra work in the 1980s, pushed at both ends from the reduction in ancillary support and the expansion of nurses' clinical role and squeezed by extra administrative work, technological change and higher dependency of patients. The reduction in doctors' hours and move to primary nursing implied in the Citizens' Charter would exacerbate these effects (see Staff Side Evidence, 1993:12-17). This has provided the impetus to review 'skill-mix' and reallocate non-nursing duties. However, against a background of a declining nurse employment

level, the 'solution' sought by managers was more resources not a change in grade-mix or task allocation.

The attempt to bypass nurse managers may be flawed at a more fundamental level. On their view and on the evidence, clinical grading had raised, in a most uncomfortable way, the possibility of a radical overhaul of historical inequities - and then failed to deliver because of the cash-limited nature of the exercise and deep divisions over definitions of tasks and skills and how individuals should be trained, deployed and evaluated. The following quotes from local managers illustrate some of the diverse views and confusion with respect to task allocation, skills and valuation:

Clinical grading was more or less a once and for all exercise - we now specify job tasks in the job description and advertise it as such. People either accept it or not, with the possibility of developing the job later and then applying for a regrade. This will mainly be an internal affair - not the same as clinical grading.

Clinical grading means that skills can now be more precisely arranged - this links in to HCAs and Project 2000.

Clinical grading was traumatic because there was no reward for service - only for the job itself. People misunderstood that. NAs were all put on grade A and it's now harder for RGNs to go up the structure.

For NAs, the criteria for advancement were based on 'supervision'. No recognition was given for competence but we need to recognise those that are 'exceptional'.

Management and staff didn't agree on the definitions of 'continuing responsibility' and 'supervision' - and probably never will! The aims of clinical grading were never realised.

The above quotations illustrate that, at the sharp end, there is little agreement on the normative basis for work organisation and valuation. Clinical grading opened a Pandora's Box, took a peek inside and then slammed the lid shut again because of the cost implications and the major points of conflict that were revealed. In this view, professional judgement has always been a fundamental part of the hierarchy within a system, which is internally and externally

unfair. Their major role has been as mediator in their attempt to make the system work and this has attracted criticism from nurses and other managers alike. The attempt to bypass such managers may, however, prove a very high-risk strategy particularly in the context of a cost-minimisation strategy which may prove ill-founded and confused in the light of historical experience and the analytical framework provided here with which to view it.

CONCLUSIONS

The analysis conducted for grade-mix in the 1980s has suggested that grade-mix changes occur for a variety of reasons, some of which have been relatively mechanistic and others less so. However, a critical linking factor has been the wider underresourcing of the public healthcare system and the nursing workforce in particular. It has been argued that this led to a 'crisis' in the late 1980's which has, if anything, been exacerbated by training changes and the drive to 'reprofile' the nursing workforce. The normative ideal models held by various parties reveal the deeply-contested nature of skill evaluation and valuation. None of these models offers a simple 'cost minimisation' strategy for government. Against this background, the analysis cautions against 'quick-fix' and simplistic approaches to grade-mix, skill-mix or skill dilution changes in the 1990s. The analysis similarly warns against the policy of attempting to dilute the role of experienced 'professional' managers as this neglects the nature of their mediating role in a hierarchical and conflictual system.

CHAPTER EIGHT

CONCLUSIONS: PAY POLICY AND THE LIMITS TO DECENTRALISATION

In this concluding chapter the main strands of the thesis are drawn together in a consideration of changes in policy towards the determination of nurses' pay in the 1980s. This analysis sets nursing pay policy in the wider theoretical and empirical context of public sector pay and collective bargaining and addresses the thorny issue of the role of government as employer. It is argued that an assessment of the degree of change is influenced by the time horizon and level of aggregation employed. Inevitably, the methodology employed gives rise to a particular view of the role of government as 'model employer', which has interest for current academic debate on public sector pay policy. In the course of this discussion, the research findings on the importance of non-pay issues and of a joint analysis of institutional processes and outcomes will be highlighted.

An underlying theme in the chapter is the long-standing debate on the relative importance of economic and institutional factors in wage determination, discussed briefly in Chapter One. Some conclusions of broader significance can now be drawn from the study of nurses' wage determination. In particular, it is argued that the modern form of this debate needs to be recast along the lines advocated earlier by writers such as Phelps Brown and Wootton to re-address questions of power and political choice and to view wages as primarily a social relation. The discussion of changes in the 1980s is extended finally to a consideration of the prospects for nursing pay policy in the 1990s. It is concluded that a policy of decentralisation, to whatever extent it is realised in practice, carries attendant risks and uncertainties as it is based on a policy of confrontation rather than accommodation and neglects sources of conflict inherent in the conduct of wage policy.

THE CONTEXT AND COVERAGE OF COLLECTIVE BARGAINING

One of the most important debates in industrial relations in recent years has concerned the extent to which the industrial relations environment has changed with the election of four successive Conservative governments since 1979. These governments have been committed to the philosophy of 'market forces' and 'rolling back the state', but equally they have exhibited a 'deep antagonism to trade unions, which are seen as impeding the functions of the labour market' (Fredman & Morris, 1989a:1). A major part of this debate has concerned pay determination and in particular the structures, processes and outcomes of collective bargaining over pay, as one of the more visible and economically significant features of industrial relations systems. As Millward et al note: 'none of the main economic actors in the country could be indifferent to levels of pay and changes to those levels' (1992:217), and this could be considered to be particularly pertinent to the government in its role as employer in a labour-intensive sector. Government policy in the 1980s and early 1990s:

'both through its dealings with its own employees and through persuasion and advocacy to other employers, encouraged a move away from national, multi-employer pay settlements towards more locally determined ones which were more sensitive to local labour markets and the circumstances of the employer...with this there was a pervasive advocacy of payment systems that reflect the performance of individual employees' (ibid).

The wider context of labour market and legislative changes are clearly important, though their relative impact remains deeply disputed, and trade union membership and density declined in the 1980s. In reviewing the WIRS3 evidence on collective bargaining, Brown has noted that 'the coverage of collective bargaining has contracted substantially...the scope of bargaining has narrowed...the depth of union involvement has diminished...and...organizational security offered to unions by employers has deteriorated' (1993:197). With particular respect to pay determination, the most striking change in the 1980s has been the shift to non-collectively bargained pay settlements which has occurred in private sector manufacturing, services and the public sector (Millward et al, 1992:Chapter 7).

Whilst multi-employer bargaining remains the most important bargaining level across the economy, the level of bargaining has shown differential change across the sectors with a shift to single-employer bargaining levels most marked in private sector services.

For the public sector, Millward et al note a substantial drop in the proportion of workplaces with collective bargaining, with almost all of the fall being in multi-employer bargaining in local government (1992:232-3). However, the shift for manual and particularly non-manual workers from collective bargaining to determination by a review body is another major change, along with the greater influence of management at a higher level. Taking the public sector as a whole, Millward et al were able to report that 'in early 1990 it remained the case that rates of pay were hardly ever settled at the level of the individual workplace in the public sector...there is no indication...of any delegation of pay determination to local levels'. They did, however, include a special note to the effect that 'there have been several moves in the public sector which are intended to increase the amount of decision-making at local level' (Note 14, *ibid*:271).

At this level of aggregation and detail, and given the 1990 survey date, there is little evidence to suggest widespread change in the nature of pay determination in the public sector in the 1980s other than in the coverage of collective bargaining. The view of pay review is evidently crucial here to a perspective on the extent to which collective bargaining has diminished and change has occurred.

This evidence may be contrasted with the perspective provided by a change in focus and level of aggregation to that of the public sector alone and the role of government as employer and formulator of public sector pay policy. A recurrent concept in industrial relations literature has been that of the state as 'model employer' and this is given recent expression and particular emphasis in the work of Fredman and Morris (1989a, 1989b). This perspective undoubtedly hinges upon an emphasis on the autonomous role of government and structural and

procedural arrangements. Thus, Fredman and Morris are able to argue that 'an important aspect of the State in its role as employer was its desire to set an example to the private sector...indeed, this was one of the primary motivations for the introduction of collective bargaining into the civil service in 1919' (1989a:10). Despite noting some problems with the 'model good employer ideal' in terms of pay outcomes in parts of the public sector, they argue that the ideal 'remained a central part of the ideology of successive governments until 1979' (ibid:11), with the encouragement of trade union organisation, commitment to collective bargaining and high degree of job security offered (ibid:1). The period since 1979 is then contrasted as representing a transformation of the role of the State as employer, with the direction of influence reversed and the government attempting to 'apply private-sector, free-market ideas to its own employment practices' (ibid).

Fredman and Morris argue that 'the attitude of the government has changed radically...increasingly opposed to industry-wide collective bargaining' and placing more emphasis upon market forces and individual performance than on the criterion of 'comparability' which was previously, and especially since the Priestly Commission (mid-1950s), 'the primary principle, combined with the desire to be a generally "good" employer' (ibid:142-3). They note that collective bargaining remains the most widespread method of determining pay and conditions in public services but also that there have been twin strands of change in both increased centralisation and control (review bodies are seen as an expression of this) and fragmentation and decentralisation (ibid:195, see also Brown & Rowthorn,1990:10-11). At this lower level of aggregation, therefore, change is given a greater emphasis and is traced directly to a change in the role and perceptions of government. Implicit in this analysis, is the linked idea that institutional expressions of comparability and fairness, as opposed to 'economic' criteria, traditionally formed the main basis for public sector pay determination.

The view of 'model' or 'good' employer has been a common one in industrial relations writing on the public sector. Thomson, for example, agrees with the basic concept but argues that the breakdown occurred earlier:

There has arguably been a breakdown in the tacit agreement whereby public sector employees...did not use their full bargaining power in exchange for the acceptance by public sector employers of "good employer" obligations...in considerable part this breakdown has been the result of what has been felt to be discrimination by governments in the operations of incomes policies' (1983:144).

The form of analysis conducted by Allen (1960:Chapter Two) of the relationship between trade unions in various parts of the public sector and the government contrasts starkly with this perspective. Allen worked from first principles in an empirical account of the history of wage determination, particularly for the civil service, to obtain a view of the role of government. His findings could be seen as period-specific but have interesting resonance with Wootton (1955) and Clegg and Chester (1957). In his coverage of the development of wage determination mechanisms for the civil service, it is clear that concepts such as 'fairness', 'comparability' and 'model employer' have played a shifting historical role, dependent largely on the power relationships of the time. At one stage he notes that the Tomlin Commission (1929-31) 'rejected the proposal that the Government should be a model employer because it considered the phrase was meaningless (1960:86). 'Fair relativities' were here substituted and used in the sense of an economic signal to ensure equilibrium between labour supply and demand: this concept was in turn swiftly attacked and finally rejected by the 1953 Commission. The notion was replaced by that of 'fairness', which as Allen notes 'had no precise meaning...its definition varied with every interest group in civil service affairs' (ibid:87).

Commenting on wage outcomes in the first decade after World War Two, he concluded that the behaviour of the successive political administrations of the time denoted a failure to 'behave as a good employer' (1960:102). In practice, the government gave priority to

its role as regulator of the economy:

where this...required a policy of wage restraint, the government applied the policy directly to its own employees...it did so not only because it was the easiest course to take but also because it acted as an example to private industry' (ibid:113)

This literature begs some questions on the causation, extent and timing of change. These issues are now addressed through a review of the findings on nursing pay determination.

CONTINUITY AND CHANGE IN NURSING PAY DETERMINATION

This thesis has provided an account and evaluation of nursing pay determination employing a methodology which has used overlapping and increasingly shorter chronological periods and increasingly lower levels of aggregation. In this way, the evolution of change from underlying continuities in past practice has been emphasised, along with the importance of non-pay issues. This detailed analysis of nursing pay determination allows some reference back to the above, and wider, debates on pay determination and the extent of change in the 1980s.

In Chapter Two, it was emphasised that the determination of nurses' pay exhibited a degree of historical intractability which could only be understood by a broader understanding of the development of public healthcare provision and of nursing in the healthcare division of labour. The development of nursing representative organisations was seen to be rooted in these; in particular in the forms of segmentation and hierarchy in nursing, influenced by wider changes in the labour movement and wider social and political change. On this account, it was the delicate interplay between, and relative strength of, the different nursing organisations that led change in industrial relations systems. In particular, the growth of trade union organisation, as opposed to professional associations, led change in the latter and in employers' strategies. Although professional associations also had an impact on employers, their effect on labour costs remained ambiguous. In part, their incorporation into the

health hierarchy could be viewed as supportive of the system more generally and counter-productive to the unity of nursing representation along wider trade union and political lines. Their strategy of professional closure, however, presented a costly alternative, as could also be seen in Chapter Seven.

In this context, the two major changes in nurses' pay determination this century - 'free' collective bargaining under the Whitley system in the new NHS, and various pay review exercises - could be seen as a reaction to the dramatic growth in trade union membership which threatened to become the dominant form of representation both prior to WW2 and prior to the establishment of the PRB. In turn, the growth of trade union membership and militancy could be seen as part of nurses' reactions to continuing low pay and grade dilution, premised on successive private and public sector employers' attempts to cost-minimise. The main alternative reaction by nurses appeared in this broad historical sweep to be 'voting with their feet'; the history of nursing pay determination changes is peppered with episodes of public pressure applied over nursing labour shortages.

It has also been argued that the establishment of 'new' pay determination systems did not mark as sharp a break with the past as might have been imagined. In this respect, the adoption of 'free collective bargaining' for nursing pay determination under the new NHS was accompanied by systems of representation in the new institutions which were weighted in favour of professional associations and government and gave little voice to local managers. It was noted that, on some arguments, the gains made by trade unions through external pressure and militancy thus accrued to the professional associations. Perhaps most importantly, it was argued that government exhibited disproportionate power to influence the structure, processes and outcomes in this system, albeit with temporally-dependent and diverse objectives. In particular, the importance of 'ability to pay' or 'economic and financial' considerations were seen to be constant emphases in government rhetoric along with a desire to set an example to the private sector through the suppression of nursing pay. The

criterion of 'comparability' came to the fore at times of greater conflict and unrest, but was still bounded by 'economistic' terminology and reasoning. This was particularly evident in the process of arbitration and special reviews (below). On this reading, pay determination systems did not work fully to either 'incorporate' trade unions or take their collective voice into account, and the material basis for conflict - that of poor pay and conditions - continued, giving rise to sporadic crises in the system and the need for arbitration or special reviews. It was further argued that these latter institutions were again 'skewed' in terms of structure, process and outcomes to the maintenance of the status quo, whilst allowing some latitude for government to distance itself from more favourable settlements designed to reduce conflict in the short term.

The establishment of the Pay Review Body arose from the contradictions in past practice, particularly in the poor material outcomes in nurses' terms and conditions and the growth of trade union power. In Chapter Three, it was argued that the PRB emerged from prior forms of arbitration and review in nursing pay determination and the extant system of pay review bodies for other staff groups in the public sector. Viewed in this perspective, the PRB made some sense: it provided a filip to professional associations - in particular, the RCN with its 'no-strike' clause; it split nurses from other health service workers, notably ancillary workers who subsequently experienced considerable deterioration in their terms and conditions of work; and it restored the status quo. However, this particular form of pay determination - a non-representative, non-accountable body - makes less sense against liberal pluralist theory or the government's own rhetoric of market forces.

The structure, processes and outcomes of the nurses' PRB were explored in Chapters Four and Five. It was argued that the review body system works in a complex way and with ambiguous results and consequences. Both the structure and processes could be seen to be 'skewed' in conservative directions and weighted in favour of government. However, the ability of Staff Side to persist with a

'negotiating style', the publicity of the proceedings, the necessity for the PRB to appear 'independent' and take arguments into account, and the continuing importance of negotiation over linked, but not directly pay-related, issues which has proved essential for the functioning of the PRB, begs the extent to which collective bargaining has been replaced and goes some way to explaining why *Staff Side* appear attached to the practice of the PRB. Focusing on outcomes, however, provides an alternative way of viewing the pay review system. Here again the disproportionate power of government is evident, yet this might be viewed as a component part of this system rather than an aberration.

In this view, the structures and outcomes of the system provide the strongest basis for, and understanding, of the material outcomes. The ceremony and apparent 'fairness' of the intervening process legitimate conservative and 'unfair' structures and outcomes, not least of which is the continued low valuation of nursing in the occupational wage hierarchy and particularly as a gendered profession. The complexity of this system arises from the fact that some degree of material accommodation is afforded through the Review Body. The fact that such accommodation appears to occur on electoral cusps suggests again a strong role for government. A corollary to this argument would be that the material basis for conflict has not been fully addressed and conflict may have been driven down to lower levels and other, non-pay, issues. This latter point could be seen both in the detail of arguments put forward in process and in the particular conduct and outcomes of the clinical grading exercise and both of these have significance for wider debates on pay determination and decentralisation.

Perhaps the most significant points which would strike the casual reader of arguments put forward in the pay process in Chapter Four are the degree of conflict generated over most criteria and the relative strength of *Staff Side* arguments as the basis for longer-term stability. It was noted in earlier chapters that the basis on which public sector pay policy should operate for distinct staff groups is

by no means clear even in the government's own rhetoric and terms of reference. Thus, ability to pay and recruitment and retention are not 'compatible' criteria and this problem is exacerbated if more localised or individualised pay determination is successfully encouraged. In practice, however, a strong historical and economic argument lies in the 'satisfying' of occupational labour supply deficiencies and it is thus not surprising that recruitment and retention have come to the fore in most public deliberations of nursing pay, including in the PRB process, although it has been argued that this also occurred for tactical reasons.

The continuing importance of the comparability criterion could also be seen in the occupational supply and demand arguments. It was argued that the breadth of the arguments entering under the comparability criterion are frequently underestimated, along with their potential for tactical use by both Sides. Moreover, and contrary to the established wisdom, comparability does not necessarily constitute an 'institutional' or 'customary' argument which can be automatically counterposed with 'economic' arguments. In the case of nurses, and using a grossly simplified economic model, an illustration would be as follows. Nursing pay determination could be modelled historically as a bi-lateral monopoly, with a disproportionately powerful monopsony (government) and a weaker labour monopoly (Staff Side). Under these conditions, and using a private sector model, both wages and employment would be below 'competitive' levels. The comparability argument enters here as a signal of the 'going rate' or 'competitive' wage levels and trade unions can act to positively increase economic welfare. An interesting corollary of this, admittedly imperfect, argument is that labour demand rather than labour supply is here seen as the factor inducing lower employment. This has some interest for the findings in Chapter Six from fieldwork interviews with managers, where the system emerges as one which is largely demand-driven. These findings suggest a more complex historical picture where shortages may be as much a reflection of resource constraints as of labour supply deficiencies. Paradoxically, severe resource constraints could also

lead to the underestimation of labour shortages as establishments are actually cut and vacancies therefore go unreported.

The above model can provide only an imperfect characterisation of some of the economic forces in nursing pay determination. It draws from a private-sector, profit-motivated, model which may not be appropriate for the public sector, where government has additional, and often countervailing, objectives to labour cost minimisation. It fails to capture the dynamic nature of power flows within and between the Sides, and fails to capture the social structures and relations involved, and the role of mediating institutions and non-pay issues, all of which this thesis has emphasised as important in an understanding of nursing pay determination. Nonetheless, it provides an interesting way of looking at the role which has been played by the comparability criterion in the pay process and its linkages with recruitment and retention and wider resourcing issues.

It was also argued in Chapters Four and Five that the pay review process was notable for the general failure to take low pay and equal pay arguments seriously and thus, that the PRB plays a role in suppressing pay aspirations. These criteria carry great force against the evaluation of material pay outcomes conducted in Chapter Five for this highly gendered and occupationally segregated workforce, with a substantial representation of part-time and ethnic-minority workers in the lower parts of the nursing hierarchy. These issues address the more fundamental questions about wage hierarchy and social structures raised in a much earlier literature by writers such as Phelps Brown and Wootton and return us to the issue of 'normative' public sector pay policy.

For these writers, the debate over the relative importance of broadly economic and broadly social factors in wage determination is in some respects a false dichotomy. As Phelps Brown argued, 'the starting point of economic and sociological theory are alike - the abstraction of certain human propensities...the difference between them lies in the propensities they abstract'. Thus, for the sociologist, 'there is

not so well defined a boundary as for the economic man between self and others...an act of exchange is essentially the manifestation of a personal relation'. Under this view, the inequality of pay is seen as 'one of, and one with, the various manifestations of social inequality'. Social status and a 'hierarchy of esteem' are thus important factors expressed through 'deference' and 'derogation' (this has evident significance for the hierarchical organisation of nursing), and such factors lead writers such as Talcott Parsons, Wootton and Pen to relegate economic factors to secondary place. Moreover, Phelps Brown went on to explore the fact that social status and hierarchies do not arise as accidents, but as part of wider structural factors, notably class and the linkage between class privilege and the exertion of power (1977:17-21). Thus 'without reference to the purposive exercise of their power and advantage by more privileged groups and strata...it has not proved possible to explain social inequality otherwise than as a structure with important self-maintaining properties' (Goldthorpe, 1974:229, in *ibid*). For Phelps Brown, the importance of this debate between 'economic' and 'social' factors turned on its empirical testing and had great implications for the potential for reducing pay inequality.

For Wootton, too, the dichotomy between economic and social factors was miscast. Rather she saw 'the contemporary wage and salary structure...as the accumulated deposit laid down by a rich mixture of economic and social forces, operating through considerable periods of history'. However, economic forces, though important, were here clearly seen as subordinate: 'political and social factors do not operate in complete disregard of economic realities' (1955:161). In concluding her study of the relative rigidity of social and wage hierarchies and relative lack of normative wage policy, Wootton notes the extreme forms of conservatism which are embedded in institutional wage determination (*ibid*:162-3). Unfortunately, she remained somewhat ambivalent on the relative part played by those structures and processes and the relative part played by social attitudes. The structural nature of pay inequalities is signalled though, this time, with a rather different line of causation. For Wootton, 'these

inequalities must carry the lion's share of responsibility for the division of our society into a hierarchy of social classes' (1955:161-165).

The important point for Wootton was that 'wage policy is in fact the instrument as much of social as of economic purposes; and on economic and social grounds alike, some policy is imperative' (ibid:166). Wages thus become a 'political' question, pertaining to the desirability of relative factor share distributions, and policy cannot be 'taken out of politics by the simple device of handing it over to a non-political body' (this has evident connotations for the PRB) (ibid:167). However, Wootton notes in passing her disappointment that the Labour Party had abandoned its equalitarian goals and restates her view, quoting Tawney (1952) that social equality is not only a desirable good in itself but 'also that the future of democracy depends upon this broadening of its foundations; and that the broadening of those foundations means the "destruction of plutocracy and the setting of an equalitarian society in its place"' (ibid:177).

Wootton could be criticised in her conclusions for a relative failure to explore power and an inadequate explanation of the directions of causation between class and inequality. However, the importance of the above debates by Phelps Brown and Wootton lies in their power to redirect attention from the more banal and economic discussions of wage determination and wage structures to the social relationships and decisions embodied in them. Without this reminder, it might be possible to specify a 'rational wage policy' towards the determination of nurses' pay as being one which might address narrowly construed issues of long term equalisation of demand and supply, as opposed to one which acknowledges the fundamental conflict raised by differing social evaluations of worth and uneven power relationships.

Expressions of this deeper point of conflict were seen in the latter chapters of the thesis and raise some critical questions for the future conduct of government policy. The clinical grading exercise and notions of 'ideal models' of the nursing workforce were seen to

embody some basic points of difference over work organisation and valuation which, again, are rooted in unresolved historical problems. What to some might appear the relative stability of the pay and social hierarchy in nursing could here be seen to be based on a morass of contradictions and conflict over whether pay should pertain to the job to be done, its constituent tasks and 'skill' requirements, the job which is actually done, or the person doing it. Most significantly for the clinical grading exercise, the words 'skills', 'responsibility', 'experience' and 'supervision' raised more questions than they solved. The debate on 'ideal models', training and 'grade-mix', reviewed in Chapter Seven, was similarly seen to hinge on differing social perspectives and views on hierarchy or egalitarianism, which, in some respects, made for some strange political bedfellows.

It can be seen that the relative stability of the nursing structures at any one time is the brief reflection of the relative balance of power within and between the Sides. However, in Chapters Six and Seven the role of managers was also signalled. It was suggested that managers perform an important role in the mediation of conflict through their adherence to some notion of 'professional and adequate' standards. This role may act mainly to sustain an 'unfair' system, and almost certainly reflects the balance of power between the 'professional' and 'trade union' strands of representation, and between these strands and government. As such this role performs a crucial function in the maintenance of hierarchy and can only be ignored by government at its peril. One of the major changes was, in fact, seen to be the treatment of nurse managers by government. In its search for a cheaper grade-mix, the maintenance of the status quo is also threatened by the downgrading of managerial responsibility.

THE TREND TO DECENTRALISATION

A similar threat to the wage hierarchy and wage determination and an important change in emphasis in the 1980s might be seen to lie in the constant trend to decentralisation seen in Chapters Four and Five to be undermining the pay review system. In the latter Chapters of the thesis, the importance of non-pay issues was signalled, both to the wage determination process and to a broader consideration of influences on wage determination: employment changes. Pay restraint and grade-mix have historically been the twin strands in cost minimisation strategy and these are viewed as the main elements in the recent arguments for decentralisation. It should be evident that these are by no means the only possible cost minimisation strategies, and the lower level of aggregation in Chapter Seven enabled the perception that the consistent underresourcing of the 1980s has 'squeezed' employment levels and led to an intensification and extension of nursing labour along with a shift in actual service provision.

However, there are qualitative differences between these 'strategies'. It has been demonstrated that there is an 'ordering' of areas where policy may have more or less direct effects, in which pay is a primary area. Grade-mix changes have been shown to arise as partly an effect from decisions on pay and funding and partly a result of policy emphasis, but with some unpredictable effects due to the lower levels at which grade-mix is decided. Labour intensification or extension is driven down to yet lower levels of determination, has very finite potential and eventually spills over into declining service provision and problems of morale. Similarly, employment changes will be made at local level and may be unpredictable. The thesis has shown the high degree of interlinkage between these areas, but it can be stressed that 'policy' instruments which have no target objectives can hardly be viewed as policy. In this respect, a 'policy' of tight cash limits and underfunding is no policy at all as it produces uncertain consequences. Neither can policy instruments which work only indirectly, such as those on grade-mix, be considered very effective.

Pay determination is thus a primary area where government can and should be expected to have a policy and to anticipate the impact of such a policy.

It is here, however, that the central dilemma for government is revealed along with the major policy deficiencies of the 1980s. It has been argued that pay determination mechanisms and processes for nurses have historically acted mainly to suppress pay outcomes, not least through the restoration of differentials and the hierarchical status quo. However, it has equally been argued that such mechanisms and processes have not 'resolved' fundamental conflict over pay but have rather provided temporary expedient 'solutions' largely as a reaction to industrial pressure and conflict. The background to the establishment of the nurses' PRB was located in both this context and the context of representational changes brought about by lower order effects of grade-mix changes. The main function of the PRB in a strategic sense was to curtail the growth of the TUC-unions and redress the balance towards the professionalisers. In this respect alone, the PRB might be viewed as a strategic success.

In its 'permanent' nature, however, the PRB has presented new problems. The need to 'restore the balance' in favour of 'professionalisers' in the 1980s has been costly. It has been argued that the mechanism itself has largely constrained pay. Unqualified staff have done badly and qualified staff, though doing rather better, have yet to regain their 1974 position in the pay league. However, the filip to the professional lobby has carried attendant pay pressures and, more particularly, associated costs in terms of training and grademix. Indeed, in this light both clinical grading and Project 2000 may look like critical policy weaknesses as opposed to strategic moves. Project 2000 was found to have enormous cost implications at a time when most managers felt they were already at crisis point. It is perhaps not surprising that training responsibility is currently being devolved (to regional level) away from more public levels of accountability. At the same time repeated exhortations to change grade-mix had little effect and it has been

argued that this was due in part to the strength of the professional lobby and managers. Even if the concurrent moves to institute NVQs and HCAs is viewed as strategic and aimed towards grade dilution, as many nurse practitioners and trade unionists have viewed these, the manner of such change must be regarded as convoluted and expensive.

In this respect, cost-minimisation policy may be seen as currently severely constrained. At the same time that the filip to 'professionalisers' granted through the PRB and its recommendations has made grade dilution an ever more attractive option through the low pay awards for the lower end of the nursing hierarchy, the professional unions and lobby are in a good position to resist such change. Altering the balance of power between 'professional' and 'TUC' unions is not currently an option, partly because in its antagonism to trade unionism the current government has no means so to do.

The drive to decentralisation of pay determination - and the limits to it - may be understood in this light. It is instructive first of all to distinguish the rationale put forward by government and management for decentralisation more generally and specifically for the NHS and nurses. It was argued in Chapter Five that change for nurses has occurred on three related, but conceptually different, levels: fragmentation, decentralisation and individualisation which are commonly considered under the broad title of decentralisation. It has also been seen that change in all three respects is well under way and has already undermined the force of national pay determination in nursing, as in many other areas of the public sector.

Government rhetoric for the public sector more generally has emphasised individualisation. The government has thus appeared keen to:

'encourage employers to move away from traditional, centralised collective bargaining towards methods of pay determination which reward individual skills and performance; respond to the wish of individual employees to negotiate their own terms and conditions, and take full account of business circumstances [and to]...embed these changes in the public sector, which in some places has lagged behind best private sector practice' (People, Jobs and Opportunity, 1992).

At the same time, and with a slightly different emphasis, the government has fuelled the debate around 'managerial prerogative' and 'local decision-making'. For the NHS, the Warlow Report presented the results of a review of the conditions of employment of NHS staff, the purpose of which was 'to identify management's requirement for change' (1989:1). The conclusions of this report were that 'the great majority of managers are looking for changes to the conditions on which staff are employed in the NHS', with the direction of such desired change being seen as more local determination of conditions and, implicitly, pay - 'rewarding local staff so as to stimulate motivation and improved performance' (ibid:45).

The same report indicated some of the thinking behind the desire for more localised determination of pay and conditions. It was argued in the report that the lack of 'individual staff or group transactions with the employer' and the prevalence of national arrangements communicated largely by professional and trade union organisations generate circumstances in which it was 'not surprising that many staff appear to have greater allegiance to their professional body or trade union than to the local employer' (ibid:46). Following on from this, it was claimed that:

'Providing effective and efficient services requires the commitment of staff. Engaging that commitment...requires local managers to have a more significant and comprehensive relationship with local employees and the reduction of influences outside of that relationship. An essential element in the relationship is the employer's control of the arrangements which apply to individual members of staff and to groups in the employment' (ibid:47).

The NHS Management Executive (NHS ME) subsequently adopted the report and signalled to Staff Side of General Whitley Council that it wished to discuss changes (in Letter from Ada Maddocks, Staff Side Secretary, 13.3.1990).

If the desire to bypass collective representation and collective bargaining is fairly clear from the above, it is less so in Dyson's

1991 paper for the NHS ME which omits to mention industrial relations. However, this omission is explained to some extent by his focus on a 'human resource strategy' (1991:1). Having recognised that such a strategy must be composed of both 'a remuneration or reward strategy and a labour utilisation strategy', in order to effect the 'substantial reductions in unit labour costs...vital to the success of many Trusts' (ibid:2), he goes on to focus ostensibly on the labour utilisation aspects. The report however goes much further than skill-mix to discuss conditions of employment and, implicitly, pay. For example, it is suggested that more 'flexibility' can be achieved through the use of contract (self-employed) staff and staff on 'personal contracts' (ibid:6-7). For Dyson:

'personal contracts offer the most exciting prospect across the range of labour utilisation issues...the offer of personal reward for a personal service can be tailored to meet the needs of staff, patients and Trust objectives' (ibid:7).

This comment on the need for change in pay determination and grademix is echoed in comments made by the NHS Deputy Personnel Director in 1989:

'[managers] have not had the benefit of controlling two main levers available to managers in other organisations; first, pay and payment systems, and secondly, the freedom to profile the workforce in the way that they felt would best deliver high quality, cost-effective services...The changes now taking place provide a window of opportunity to break free of the constraints to effective human resource management, and to focus events and attentions at local level' (Johnson, 1989:10).

It can be seen from the above, that the force of the arguments for decentralisation concern 'individualisation' of pay and other terms and conditions and the 'freedom to reprofile' the workforce. Cost minimisation is clearly seen as an objective of such change. The actual arguments for decentralisation range from importing private sector 'best practice, the desire of individual employees and managers for change, and the establishment of effective human resource management. These arguments are now discussed in turn, and highlight the limits to such decentralisation.

Looking firstly at the arguments around private sector best practice, it has been strongly argued by a number of academics that this more general argument for decentralisation in the public sector may be based on a very flawed view of a more general decentralisation in the private sector. As noted earlier decentralisation to some extent has occurred in the private sector (Millward et al, 1992), but it has been argued that product market competition rather than labour market changes have been the driving consideration (see Purcell, 1991; Purcell & Ahlstrand, 1988). Brown & Rowthorn have emphasised this point, and also pointed out that private sector managers have reacted to particular geographical labour market problems, for example in London by building up 'specific and identifiable London allowances' (1990:12) rather than by deviating from a pay structure based on product rather than geographical markets. Related to this point, Brown & Walsh have further suggested that decentralisation in the private sector should also not be 'exaggerated' as 'plant management may only be given freedom to negotiate within strict financial limits, or it may have to check with the divisional or corporate management before concluding a pay deal' (1991:50). Thus, Brown & Rowthorn have argued that 'decentralisation of pay fixing is feasible in the non-geographic, functional sense only insofar as the separate functions are truly independently accountable' (1990:13).

Quite apart from actual practice in the private sector, the relevance of this practice for the public sector has also been questioned. Thus, Brown & Rowthorn have argued that neither geographic nor functional decentralisation make any sense for many areas of the public sector which 'still possess clear national coherence in terms of finance, regulation, and occupational integrity'. In the latter context, they note that in any case 'in contrast to the rhetoric of decentralisation, most public service pay bargaining has seen continued tightening of central Treasury budgetary control during the 1980s' alongside the continuation and establishment of new review bodies. Moreover, it is extremely hard to establish performance indicators for many public sector services and therefore to develop management tools employing such indicators. They also argue that a

national pay structure 'is an integral part of the means they [the public service professions] use to maintain their professional standards' and also facilitates labour mobility. Thus, the attempt to decentralise would be a 'prescription for leapfrogging comparability claims, geographical immobility, and low professional morale' (ibid:10-13).

The second major argument for decentralisation - that it reflects desires on the part of employees and managers - can now be evaluated. In the documentary and fieldwork research for this thesis, not a single argument was heard from either employees or managers for decentralisation or individualisation of pay determination. Staff Side have been deeply resistant to the erosion of national pay determination and the fragmentation of arrangements and this continues to be their position. Individual nurses and midwives in interview expressed no desire for individualisation of their terms and conditions. The only exception to this, was the readiness of some national and local union representatives to respond positively to local pay determination if such a situation arose, given a degree of private frustration with the conservatism of national pay determination mechanisms. Similarly, there was no desire on the part of the managers interviewed, and who have been for the most part intimately connected with nurse resourcing for decades, to see local or individual pay determination. If anything, the individual claims involved in clinical grading had convinced most of the undesirability of such a change. National pay determination left managers free to manage.

Likewise, managers in interview expressed no desire for greater 'freedom' in 'reprofiling the workforce'. Taking skill- or grade-mix as the core of this argument (rather than personal contracts which more properly relate to pay - see above), it was seen in Chapters Six and Seven that most managers had indeed exercised the freedom they already had to take decisions on grade-mix and that such decisions may actually have stalled or even countered centrally-driven policy initiatives towards grade dilution. That many also felt that training

changes and resource constraints would drive such dilution changes through in future would rather express their greater desire for freedom to make professional judgements about the need for different staff and to have such judgements properly backed by adequate funding. It was clearly seen in Chapter Seven that the few dissenting voices to this view - managers who would like to see different systems of grading and reward as part of a more flexible package locally - had little idea of the cost implications of such a package. Again, Staff Side indicated that they would pursue any grading or grade-mix changes that did arise to get the best possible deal for their members.

Thirdly, the argument for 'effective human resource management' can be evaluated. In many respects, this can be viewed as the crux of the internal logic for decentralisation and the area in which wider objectives link in. Looking firstly at the argument which might be viewed as 'internal' to nursing staff, the above quote from the Warlow report clearly spells out the rationale for labour exclusion and reassertion of managerial prerogative. 'Effective human resource management' is thus largely presented in unitarist terms despite being a reaction to the policy conflicts around nurses' pay and conditions in the 1980s. Alternatively viewed, the unitarist terms belie a more radical desire to weaken and bypass trade unions. On either interpretation, there is little to recommend such an approach for nurses.

Nurses remain highly unionised; indeed nursing unionism has actually increased over the 1980s against the trend in the trade union movement. The thesis has shown a high degree of conflict over nursing pay and conditions, sometimes latent, sometimes overt. There is thus a de facto argument against a unitarist or exclusionary perspective. However, to the extent that there is a degree of antagonism towards trade unions in these perspectives, it is perhaps worth summarising the findings on trade union effects in nursing. Firstly, it is difficult to conceive how the PRB could have functioned without the trade unions. In effect, a couple of dozen people are able to consider and decide the pay of some half a million workers - an

inexpensive and streamlined system which the majority of private sector employers would envy. Trade unions effectively present through Staff Side what is already a relatively 'united' claim by these half a million workers, in a process largely dominated by the 'modest' claims of the non-TUC unions. Failing this activity, management would need to seek, whether individually or in groups, and at different levels, the same measure of agreement. The costs involved may easily be perceived to be staggering for such an exercise (see Seifert,1990:56/57) and were well-demonstrated in the clinical grading exercise.

It has been argued that pay determination mechanisms have largely had conservative effects on nursing pay and conditions, which still remain poor against many comparators. In this respect, nursing trade unions have historically acted mainly, and modestly, to protect terms and conditions for nursing staff, whether this be through improved professional status or direct wages and conditions demands. They have had to do this largely to counter successive governments' intransigence in a largely monopsonistic employment. The alternative, where trade unionism has been weak, has been a loss of skilled staff - nurses voting with their feet. There is thus a strong argument that 'effective human resource management' in the case of nurses must include 'efficient' wages and a reconsideration of nurses' claim for 'fair comparability' in the national wage hierarchy. There is therefore little to suggest that nurses could willingly be separated from their unions, nor that de-recognition or failure to negotiate at local level would be desirable in terms of service delivery.

Perhaps more significantly, given the focus on power and conflict in this thesis, the strategy of decentralisation embodies some fundamental flaws in underestimating union response. The major growth in nursing trade unionism in the 1980s has been in the RCN, although the TUC unions' membership has held constant given compositional change. The linkages in the RCN between professional practice and trade unionism have become increasingly tight since the late 1970s and as Seifert has argued 'those from closed labour markets will respond

with ever tighter definitions of professional practice' (1990:56/57). At the same time the merger between COHSE, NUPE and NALGO has been ratified and the new union, UNISON, comes 'on stream' at the very time that local pay bargaining would reunite staff at the lower end of the NHS hierarchy. The separation of auxiliaries and ancillaries in the establishment of the PRB has had deleterious effects for both staff groups in the 1980s. The re-uniting of these and other groups could help counter the effects of competitive tendering and provide a powerful boost to all nursing staff pay as it did in the 1970s. UNISON would span the NHS hierarchy up to the higher end of nursing and this could have the effect, once again, of 'galvanising' the degree of unionateness of the RCN. Perhaps most significantly, many of the trade unionists interviewed pointed to the increased membership caused by the experience of clinical grading. If pay is no longer determined in a 'remote' fashion but in local negotiations, conflict could come out at full force. This is only likely to be exacerbated by individualised pay which, in any case, has limited relevance where there are nationally and statutorily set standards of competence and de facto promotional barriers. It is thus entirely conceivable, as NHS managers are only too aware, that:

a trade union renaissance at local level is probably inevitable as unions re-assert themselves on the back of local pay bargaining (Glascott,1990:291).

It is doubtful whether NHS management are in any sense prepared for local bargaining. Considerable scepticism was expressed by managers in interview about their ability to cope with such an exercise and as Glascott has also noted '[pay determination] will be a stern test for the personnel function' (1990:291). Most felt some sort of 'network' to avoid pay leap-frogging and poaching would be necessary and this has already been established for Trusts by the NHS ME. However, this goes deeply against the grain of 'market forces' local bargaining, and it is likely that staff side would respond by coordination at similar and higher levels.

This evaluation identifies, at the very least, some very real risks for government if centralised financing is to remain and if the

government still regards overt conflict over nursing pay as politically sensitive. Paradoxically, the PRB has already been undermined by the various forms of decentralisation that have already taken place and in this respect, the government is likely to find its policy options increasingly constrained. However, a real challenge to nursing trade unionism, despite demographic change working in its favour, is the level of redundancies occurring under the new NHS system and the growth of the private sector outlined in Chapter Seven.

In conclusion, this chapter has emphasised that changes arise in this endogenous system as a result of contradictions in existing practice. Apparent stability can thus obscure dynamic changes. Above all, perhaps, it is this opaque image and an ahistorical approach which lend credence both to the view that government's traditional role has been that of 'model' employer, with the associated - if implicit - view of a relatively stable role for the welfare state. In contrast to this approach, the account of nurses' pay determination in this thesis has emphasised the importance of understanding the causation behind change: which includes the need to locate pay determination as the nexus of a wider set of economic, social and political relations. As Winchester has noted, a fuller appreciation of the particular nature of public policy and future developments awaits:

'more systematic analysis of the forms of state economic intervention and the nature of power in collective bargaining...combined with an institutional analysis of public sector industrial relations' (Winchester,1983:178).

Fortunately, there have been some signs in the late 1980's that the interest and significance of public sector industrial relations is beginning to be recognised.

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